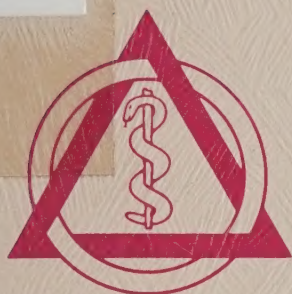




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TRANSACTIONS of the Canadian Dental Association



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INTERIM AND ANNUAL MEETINGS
BOARD OF GOVERNORS
APRIL 4-5 AND AUGUST 22-23

1986

ASSEMBLÉES INTERIMAIRE ET ANNUELLE
DU BUREAU DES GOUVERNEURS
LES 4-5 AVRIL ET LES 22-23 AOÛT

SHELVED
WITH
BOUND
JOURNALS

**INTERIM
MEETING
BOARD OF GOVERNORS
CANADIAN DENTAL ASSOCIATION**

OTTAWA, ONTARIO

April 4-5

1986

AVANT-PROPOS

Le présent document contient le compte-rendu des travaux des assemblées, provisoire et annuelle, du Bureau des gouverneurs de l'Association dentaire canadienne, qui ont eu lieu respectivement les 4 et 5 avril 1986, à Ottawa (Ontario), et les 22 et 23 août de la même année, à Halifax (Nouvelle-Ecosse).

Tous les membres de l'Association dentaire canadienne sont bienvenus à ces assemblées auxquelles ils peuvent participer.

Les rapports des conseils et des sections ainsi que d'autres documents sont présentés au cours de séances publiques. Le président peut permettre aux membres de l'Association de s'exprimer sur diverses questions mais seuls les gouverneurs ont droit de vote.

Assemblée provisoire et annuelle

Les textes inscrits en caractères gras dans les rapports des conseils et des sections, ou à la fin, présentent les observations et les actes posés par le Bureau des gouverneurs.

Les DELIBERATIONS DE L'ADC ont pour objet de fournir aux membres un compte-rendu des orientations et des décisions prises par le Bureau des gouverneurs ainsi que des travaux des conseils et des sections de l'Association.

FORWARD

This book provides a record of the business transacted at the Interim and Annual meetings of the Board of Governors of the Canadian Dental Association, on April 4-5, 1986 in Ottawa, Ontario, and August 22-23, 1986 in Halifax, Nova Scotia.

All members of the Canadian Dental Association are welcome to attend and to participate in the meetings of the Boards of Governors.

During the sessions, reports of Councils and Sections, etc., are brought to open sessions of the Board, and, although the Chairman may permit any member to speak on any issue, only Board members may vote.

Interim and Annual Meeting

Words appearing in bold both within the body and at the end of the Council or Section Reports constitute the comments and actions of the Board of Governors.

The purpose of the CDA TRANSACTIONS is to provide members with a record of the policies and decisions of the Board of Governors and the work of the Association's Councils and Sections.

CDA STAFF

S. Deziel, Executive Assistant	B. Henderson, Director of Accreditation
L. George, Information Officer	J. Scrimger, Director of Administration
C. Hackland, Editor	L. Teteruck, Dir. of Educational Services
	S. Vial, Accountant

OBSERVERS

<u>NAME</u>	<u>AFFILIATION</u>
I.C. Bennett	Dalhousie University
M. Bernstein	Canadian Association of Orthodontists
M. Boucher	Ordre des dentistes du Québec
B.L. Bowden	Newfoundland Dental Association
K. Butler	Canadian Dental Services Plans Inc.
C. Covit	Ordre des Dentistes du Québec
M.J. Crompton	Royal College of Dentists of Canada
F. Dawes	National Dental Examining Board of Canada
M.N. Deyette	Canadian Forces Dental Services
H. Dick	National Dental Examining Board of Canada
J.C. Gillies	Ontario Dental Association
T. Gushue	Newfoundland Dental Association
J. Hardie	Editorial Board
T. Howarth	McCay Duff Co.
I. Kleysteuber	Canadian Fund for Dental Education
G. Kravis	National Dental Examining Board of Canada
P.Y. Lamarche	Ordre des dentistes du Québec
C. Leblanc	New Brunswick Dental Society
B.P. Martinello	Alberta Dental Association
W.M. McKechnie	College of Dental Surgeons of Saskatchewan
R. McIntyre	Manitoba Dental Association
K. Montgomery	Royal College of Dentists of Canada
A. Newcombe	Canadian Dental Hygienists Association
D.V. Pamenter	Nova Scotia Dental Association
G.H. Peacock	College of Dental Surgeons of Saskatchewan
G.E. Pitkin	Royal College of Dental Surgeons of Ontario
R.B. Porter	Nova Scotia Dental Association
K.F. Pownall	Royal College of Dental Surgeons of Ontario
J.F. Reid	Canadian Fund for Dental Education
G.R. Sandercock	Alberta Dental Association
A. Schwartz	Association of Canadian Faculties of Dentistry
J.G. Thompson	New Brunswick Dental Society
R.E. Warren	Canadian Association of Oral & Maxillofacial Surgeons
F. Weinstein	Canadian Academy of Endodontics
R.D. Wells	Ontario Dental Association
C. Worobey	Canadian Dental Hygienists Association
P. Zakarow	Student Governor-Elect

CANADIAN DENTAL ASSOCIATION

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Secretary to the Board of Governors

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A.J. Neilson

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J.R. Robertson, President-Elect
P.R. Crawford, Past-President

G. Dubé
J.N. Wright
J.W. Niedermayer

R.J. Markey
J. Christie
E.F. Allison

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R.A. Turcotte

CDN. FORCES DENTAL SERVICES

J.N. Wright

STUDENT REPRESENTATIVE

S. Sgro

HEALTH & WELFARE

W.R. Bedford

VETERANS AFFAIRS

J.C. Tsafaroff

Recording Secretary: Mrs. M. Lynch

COUNCIL CHAIRMEN

G.H. Peacock (Constitution & By-Laws)
R.Y. Barolet (Dental Materials)
A. Schwartz (Education & Accred.)
G.R. Thordarson (Ethics)
A. Toeman (Health Care)

J.H. Gryfe (Hosp. & Inst. Serv.)
Y. Kamachi (Information Serv.)
J.E. Durran (Insurance & Inv.)
P.R. Crawford (Nominations)
L. LeSaux (Student Affairs)

LEGEND

April 1986

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EXECUTIVE

REPORT OF THE EXECUTIVE COUNCIL TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. Bradley W. Holmes, Chairman, Kenora
Dr. John Robertson, Summerside
Dr. P. Ralph Crawford, Winnipeg
Dr. Edward F. Allison, Calgary
Dr. John Christie, Bedford
Dr. Gilles Dubé, Lachute
Dr. Ronald J. Markey, Richmond
Dr. Jack W. Niedermayer, Regina
Brig.-Gen. James N. Wright, Ottawa

1. Council Meetings

Since the last Board of Governors meeting, October 3-4, 1985, the Executive Council has met on three occasions - October 4, 1985, November 16-18, 1985 and February 21-22, 1986.

ITEMS REQUIRING BOARD ACTION

2. Audited Financial Statement - Canadian Dental Association

The Audited Financial Statements for the Canadian Dental Association were reviewed and explanatory notes are appended for information.

RESOLVED:

86.1 THAT the audited statement for the Canadian Dental Association for the year ending December 31, 1985 be approved.

APPENDIX A

ADOPTED

The Chairman of Executive Council, in the context of the Report of the Council on Information Services, will report to Governors on the Dental Awareness Program budgetary element (DAP/DHM), including a separation and analysis of Dental Awareness Program budget and costs, Dental Health Month expenses, and other administrative services furnished by Manifest Communications.

3. Audited Financial Statement - Canadian Dental Research Foundation

Executive Council reviewed the Audited Financial Statements for the Canadian Dental Research Foundation.

RESOLVED:

- 86.2 **THAT the audited statement for the Canadian Dental Research Foundation for the year ending December 31, 1985 be approved.**

APPENDIX B

ADOPTED

4. FDI Delegates and Alternate Delegates

RESOLVED:

- 86.3 **THAT the CDA official delegates to the 1986 FDI Congress in Manila be Dr. Robert N. Hicks, FDI National Treasurer, and Dr. John R. Robertson, CDA President-Elect.**

ADOPTED

RESOLVED:

- 86.4 **THAT the CDA alternate delegates to the 1986 FDI Congress in Manila be Brig.-Gen. James N. Wright and Dr. George Beagrie.**

ADOPTED

5. Appointment of Auditors - Canadian Dentists' Insurance Programs (CDIP)

RESOLVED:

- 86.5 **THAT the firm of Clarke, Henning and Co. be appointed auditors of CDIP for 1986.**

ADOPTED

6. Approval of CDIP Statement of Receipts and Disbursements - 1985

RESOLVED:

- 86.6 THAT the CDIP Statement of Receipts and Disbursements for the year ended December 31, 1985 be approved.

APPENDIX C

ADOPTED

7. Academy of General Dentistry Certifying Board

A "CDA Position on A Certifying Board for General Dentistry" has been developed. This statement has been circulated to all corporate members and licensing bodies for comment.

THAT the appended "CDA Position on A Certifying Board for General Dentistry" be approved.

APPENDIX D

MOTION TO DEFER

RESOLVED:

- 86.7 THAT consideration on the above Motion be deferred until the Annual Meeting of the Board of Governors, to be held in Halifax, August 22-23, 1986.

ADOPTED

8. Protection of Tenure of Members of Management Committee and Executive Council

Immediately following the 1985 Annual Meeting of the CDA Board of Governors, notification was received from the QDSA effecting the removal from office of the Quebec representatives on the Board of Governors. This action caused the position of the Quebec representative to the Executive Council to become vacant. The Executive Council, concerned about the potential for disruption to Association business, requested the Council on Constitution and By-Laws to examine the question of immunity of members of Management Committee and Executive Council to removal from office. Related correspondence is appended.

APPENDIX E

RESOLVED:

- 86.8 **THAT** the Council on Constitution and By-Laws be requested to prepare the necessary amendment to the By-Laws required to ensure protection of members of the Management Committee from removal from office by their corporate body during their term in office.

DEFEATED

NOTE: The Board of Governors accepts the principle of invulnerability of the members of the Management Committee to removal from office by the Corporate Members.

Information on the question of impeachment will be obtained for future consideration.

DIRECTION: That the Council on Constitution and By-Laws examine the question of impeachment for consideration at a future date

A decision on the advisability of similar protection for members of Executive Council was deferred, and the Executive Council seeks the direction of the Board of Governors before proceeding further on this issue.

Following discussion, it was agreed that no further action be taken.

9. **Restructuring CDSPI Board of Directors**

At the October, 1985 Annual Meeting of the CDSPI Board of Directors, a motion to restructure the Board was defeated. Subsequent to that meeting, CDSPI requested and received recommendations from corporate members and the CDA on this matter. All comment has been reviewed by Executive Council.

RESOLVED:

- 86.9 **THAT** the CDA support the following restructuring of the CDSPI Board of Directors:
- One (1) voting director to be named from the provinces of Saskatchewan and Manitoba;

-
- One (1) observer to be named from the provinces of Saskatchewan and Manitoba;
 - One (1) voting director to be named from the Atlantic Provinces; and,
 - Three (3) observers to be named from the Atlantic Provinces.

ADOPTED

NOTE: CDA Governors from Saskatchewan and Manitoba opposed the above motion.

- 86.10 THAT the CDSPI Management Committee members all be appointed on an equal basis as officials of the Board, without votes, but must be entitled to attend all meetings of the Board.

THAT the CDA Director from Ontario be an appointee mutually agreed to by the Ontario Dental Association and the Canadian Dental Association.

ADOPTED

- 86.11 THAT the CDA Director from Quebec be an appointee mutually agreed to by the Quebec Dental Surgeons Association and the Canadian Dental Association.

ADOPTED

10. Roles and Responsibilities Committee

Following direction received at the 1985 Annual Meeting, proposed roles and responsibilities for the Executive Council, Management Committee, Chairman of the Board, Executive Director, President, and President-Elect were circulated to corporate members for comment. All comment has been considered.

RESOLVED:

- 86.12 THAT the appended roles and responsibilities for the Executive Council be approved.

THAT the appended roles and responsibilities for the Management Committee be approved.

THAT the appended roles and responsibilities for Chairman of the Board be approved.

THAT the appended roles and responsibilities for Executive Director be approved.

THAT the appended roles and responsibilities for President be approved as amended.

THAT the appended roles and responsibilities for President-Elect be approved as amended.

THAT the appended roles and responsibilities for Past-President be approved as amended.

APPENDIX F

ADOPTED

- 86.13 THAT the Motion 86.12 be passed to the Council of Constitution and By-Laws for the necessary by-law amendments.

ADOPTED

The Committee received comments from corporate members and council/committee chairmen on the present structure of CDA Councils and Committees. Based on a review of these comments, the Committee decided that for the present, the existing structure would remain unchanged. Comment received from council/committee chairmen will be studied further, and the Committee will make recommendations as appropriate.

11. Editorial Board Report

The Report of the Editorial Board is appended. Items requiring Board action are noted therein.

APPENDIX G

12. Membership Committee Report

The Report of the Membership Committee is appended. Items requiring Board action are indicated therein.

APPENDIX H

Associate memberships approved by Executive Council are as indicated.

13. Third Party Dental Plans Committee Report

The Report of the Third Party Dental Plans Committee is appended and items requiring Board action are noted therein.

APPENDIX I

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

14. Committee on Consumer Products Recognition

The Report of the Committee on Consumer Products Recognition is appended.

APPENDIX J

15. Government Relations Committee

The Report of the Government Relations Committee is appended.

APPENDIX K

Following presentation of the Report by the Chairman, Dr. Ron Markey, Mr. Jardine Neilson will address the Board on the topic of Government Relations.

16. Management Committee

On recommendation of the Management Committee, the Executive Council has approved that expense claims submitted to CDA for payment must be supported by original receipts.

Guaranteed hotel reservations will henceforth be the responsibility of the individual in whose name they are made.

An amount of \$9,700 was approved by Executive Council to cover the cost of roof repairs to the CDA building; this amount was paid from the building reserve fund.

In view of increasing requests made to the CDA for funding assistance, Executive Council has directed that in order to better assess requirements, all future funding requests for Conferences, Courses, Symposia, and Meetings, must be supported by detailed activity plan outlines.

17. Committee on Salaried Dentists

The Report of the Committee on Salaried Dentists is appended.

APPENDIX L

18. Taxation Committee

The Taxation Committee Report is appended. Discussions with the Departments of Finance, and Revenue Canada - Customs and Excise, are ongoing regarding further tax exemptions on dental materials and orthodontic materials and appliances. Information on tax exemptions achieved to date has been communicated to all dentists in Canada.

APPENDIX M

19. Convention Committee Update

An update on activities relative to CDA Conventions 1986-1988 is appended.

APPENDIX N

Dr. Ian Vogan will make a presentation to the Board on the 1986 Convention, Halifax, Nova Scotia.

Following the resignation of Dr. J.C. Giguère, Chairman, 1987 CDA Convention, Quebec City, and correspondence between the CDA and the QDSA on the advisability of holding the 1987 Convention in Quebec City, the CDA 1987 Quebec City Convention was cancelled.

20. Advisory Committee on Conventions

At the Executive Planning Session held in November, 1985, the Executive Council discussed the future of CDA Conventions in light of the 1985 CDA Convention Ottawa experience. An Advisory Committee was established, comprising members with broad convention experience from across Canada. A summary of the deliberations of the Advisory Committee is appended.

APPENDIX O

Based on its review of these findings, the Executive Council has authorized the establishment of an Ad Hoc Committee on Conventions, which will evaluate the Advisory Committee's findings, and report back to the Executive Council with specific recommendations on a protocol for future CDA Conventions.

21. Oral Medicine Specialty Status

In October, 1985 the CDA received a report from Dr. David Mock, President of the Canadian Academy of Oral Pathology, recommending that oral pathology remain a single specialty including both microscopic and clinical components. This report was based on a survey conducted of active members of the Academy of Oral Pathology, regarding the recognition of Oral Medicine or Clinical Oral Pathology as a separate specialty.

The Executive Council is aware of continuing concern in this area, and has referred this matter to the Council on Education and Accreditation, with direction that it evaluate the possibility of Oral Medicine being incorporated within the existing structure of Specialty recognition.

22. CDA Manpower Symposium - Professional Resource Utilization Committee

The CDA Manpower Symposium was held in Toronto in October, 1985. It was the consensus of the Symposium that: a manpower problem did exist; that it was complex and multi-faceted; if the problem was not addressed it would worsen; and, it is the responsibility of the CDA to seek solutions. Following direction received at the Symposium, the CDA has established a national committee - the Professional Resource Utilization Committee - to study the present resource situation, and to present recommended solutions to the CDA Board of Governors. The following are members of the Committee:

Dr. Bradley Holmes, CDA President, Chairman;
Dr. William Bedford, representing Health and Welfare Canada;
Mrs. Pat Johnson, representing the Canadian Dental Hygienists Association;
Dr. Robert Salois, representing the membership at large;
Rev. Rondo Thomas, representing the lay public; and,
Dr. Kenneth Bentley, representing the Association of Canadian Faculties of Dentistry.

The Committee has held an initial orientation and organization meeting, will meet again in April, and is anticipated to make preliminary recommendations to the Annual Meeting of the Board in August.

23. FDI - 1993

The FDI has been formally notified that, by Board decision at its Annual Meeting of 1985, CDA will submit a formal application to host the FDI Congress 1993 in Vancouver.

As required by FDI Congress protocol, an official site visit to Vancouver was scheduled for the week of February 24, 1986. An Executive meeting will also be held at that time among FDI, CDA, and CDS-BC officials. It is anticipated that the CDA invitation will be extended shortly thereafter, for consideration at the FDI Executive Meeting scheduled for May 15, 1986, and acceptance at the FDI World Council, coincident with its 1986 Annual Meeting.

24. Report of the National Treasurer to FDI - 1985 World Dental Congress - Belgrade, Yugoslavia

A detailed report on the 1985 FDI Congress has been prepared by the National Treasurer, Dr. Robert N. Hicks, and is appended.

APPENDIX P

25. Legal Opinions - National School of Dental Therapy, and Practice of Dental Therapy in Conne River, Newfoundland

Concern about the training for, and practice of dental therapy under the auspices of Health and Welfare Canada, prompted the CDA to seek legal opinions on the National School of Dental Therapy and the Practice of Dental Therapy in Conne River, Newfoundland. Two opinions were received; one from Mr. Gordon Henderson of the law firm Gowling and Henderson, and a second from Mr. J.J. Robinette of the law firm McCarthy

& McCarthy. To date these opinions have been discussed and shared with representatives of the corporate members of Newfoundland and Saskatchewan. Discussion also took place with other corporate members at the Annual Secretaries Conference.

Discussion has been initiated with officials of Medical Services Branch, Health and Welfare Canada; these discussions continue.

26. Independent Review of Dental Services - Health and Welfare Canada

CDA has been working closely with Medical Services Branch, Health and Welfare Canada, on the establishment of a Study Team to conduct an independent review of dental services delivered to Canada's Indian and Inuit populations. Ms Rebecca Martel and Mr. William Ross have been confirmed as members of the two-person review team. Ms Martel was CDA's nominee. A Statement of Work, prepared with CDA participation, is appended. At present, it is not known what effect, if any, the federal government "freeze" will have on the Review Team.

APPENDIX Q

27. Senior Consultant - Dentistry, Health and Welfare Canada

Dr. William Bedford, Senior Consultant - Dentistry, Health and Welfare Canada, has submitted a proposal to his department on the provision of dental services to native peoples by a non-governmental body. In order that Dr. Bedford not be considered to be in a position of potential or actual conflict of interest, he has been assigned to duties in the Health Services and Promotion Branch. Dr. Bedford's proposal will be considered by the Dental Services Review Team.

Dr. Donald Ross is replacing Dr. Bedford on an "as required basis".

28. Policy Advisory Board - National School of Dental Therapy

Following direction of the Board of Governors at the last Annual Meeting, discussions have taken place with Medical Services Branch on voting privileges for the Saskatchewan, Prince Albert and CDA representatives to the Policy Advisory Board - National School of Dental Therapy. The CDA has been informed that a positive response will likely be forthcoming.

The following representatives have been named to the Policy Advisory Board - National School of Dental Therapy:

-
- Dr. M.L. Simoneau of Melfort, Saskatchewan, representing the College of Dental Surgeons of Saskatchewan;
 - Dr. P. Rieben Jr., of Prince Albert, Saskatchewan, representing the Prince Albert and District Dental Society; and,
 - Dr. Bradley Holmes, representing the Canadian Dental Association.

29. CDA Participation Agreement

The 1985 and 1986 Participation Agreements between the CDA and the QDSA were signed.

Agreement was reached on the amendment of two sections of the 1985 Agreement, forwarded to the QDSA for signature.

- 1) The text of the French language version of the 1985 Agreement under Section 9 - Surpluses, has been amended to agree exactly with the Section 6 - Surpluses, in the French language version of the 1984 Agreement. The Sections on Surpluses in the 1985 and 1984 English language Agreements are identical. There had been no intent to change the French version of this Section in the 1985 Agreement.
- 2) The second change - Section 1 - makes both the French and English language versions equally authoritative, in the case of conflict in interpretation. CDSPI lawyers have assured the CDA that this does not place the surpluses in jeopardy. The distribution of surpluses remains under the authority and responsibility of the CDA Executive Council.

30. CDA Mission Statement

The CDA Mission Statement has been circulated to all corporate members for comment. A revised statement will be presented to the Board in August.

31. Canada Health Act

The CDA wrote to the Canadian Medical Association expressing its support for CMA efforts to seek clarification of the legal status of the Canada Health Act. A summary of the CDA position with regard to the Canada Health Act is contained in the Report of the Council on Hospital and Institutional Services, and is recommended for Board approval.

32. CDA Teaching Conference in Periodontics

It was the decision of the Board of Governors, at the 1985 Annual Meeting, that the 1986 CDA Teaching Conference be held in conjunction with the CDA Annual Convention in Halifax - August, 1986. Subsequently, representations were received by Executive Council from Dr. Crawford Bain, Conference Chairman, and Dr. E.E. Chesko, Vice-President of the Canadian Academy of Periodontics, indicating that implementation of this decision would jeopardize the conference. The Executive Council therefore approved that the 1986 Teaching Conference be held in Halifax - June, 1986, in conjunction with the meeting of the Canadian Academy of Periodontology.

33. CDA Position on Smoking and Health

The concern expressed by many segments of the health community on the ill effects of Smoking relative to the overall health of Canadians is strongly supported by the Executive Council. The Council on Health Care has been mandated to develop a CDA Position on Smoking and Health, to be brought to the Board of Governors for approval at a future date.

34. CDA Honors and Awards

The Executive Council is currently reviewing the CDA's program of Honors and Awards. Recommendations for changes will be developed and reported to the Board.

35. Dr. Frederic Gladstone Gollop - Bequest to the Canadian Dental Association

A bequest in the amount of \$66,000 has been made to the Canadian Dental Association by the late Dr. Frederic Gladstone Gollop, an Ottawa dentist. Information related to Dr. Gollop is appended.

APPENDIX R

A report on the disposition of the bequest is appended. However, further action on recommendations has been deferred, pending a review of "charitable" status for the Canadian Dental Research Foundation.

APPENDIX S

36. Application for Temporary Registration - Government of the Northwest Territories

A request has been received from the Commissioner of the Government of the Northwest Territories, for CDA assistance concerning applications for temporary registration. A meeting has been scheduled with officials of the CDA, the NDEB and the Government of the NWT to review this request.

APPENDIX T

37. Council on Dental Specialties

A request from the 1985 Annual Meeting of Specialty Sections, for the establishment of a CDA Council on Dental Specialties, was reviewed by Executive Council. This item requires further review, and recommendations will be made to the Board as appropriate.

38. Executive Council Planning Sessions

The Executive Council will hold a Planning Session in conjunction with the first full meeting of Executive Council, following the 1986 Annual Meeting of the Board of Governors.

39. 90 Day Long Term Disability Insurance Premiums

The Executive Council has approved a reduction in the 1986 rates for the 90 Day Long Term Disability Insurance. The new rates are appended for information.

APPENDIX U

40. Certificates of Merit/Letters of Appreciation

Executive Council has awarded CDA's Certificate of Merit to the following:

Dr. T.E. Ramage
Dr. Ken Bentley
Dr. N.H. Andrews
Dr. H.W. Horsman
Dr. A.D. Crocker
Dr. E.K. Fukushima
Dr. C.T. McNichol
Dr. R. Roydhouse
Dr. D.L. Thompson

Dr. Peter Pronych
Dr. Walter Meyer
Dr. Marc-André Morand
Dr. W.D. Sanders
Dr. L.N. Johnson
Dr. W. Teteruck
Dr. Pierre Désautels
Dr. Normand Tardif
Dr. A.B. Hord (Deceased)

Letters of Appreciation from the President have been forwarded as follows:

Dr. J.C. Giguère
Dr. Y. Giguère
Dr. G. Lovely
Dr. D. Beck
Dr. L. Trudel

41. National Dental Examining Board of Canada

At the request of Executive Council, the NDEB, represented by Dr. Henry Dick, Vice-President, made a presentation to the February Executive Council meeting, on the role and activities of the NDEB. NDEB has also been invited to make a similar presentation to the Interim Board Meeting.

42. Confirmation of Permanent Employment - Mr. A.J. Neilson

The Executive Council confirmed the permanent employment of Mr. A. Jardine Neilson as Executive Director of the Canadian Dental Association.

43. Council and Committee Appointments

Since the last meeting of the Board of Governors, the following appointments to Councils and Committees have been made by the President, Dr. Bradley Holmes:

Dr. John Christie was appointed to Executive Council as the representative from the Atlantic Provinces;

Dr. Gilles Dubé was appointed as the Quebec Representative to Executive Council, filling the unexpired term of Dr. J.C. Giguère;

Dr. Ralph Barolet was appointed Chairman of the Committee on Consumer Products Recognition;

Dr. Andrew Toeman was appointed Chairman of the Council on Health Care;

Dean Arthur Schwartz was appointed Chairman of the Council on Education and Accreditation;

Dr. Ron Markey was appointed Chairman of the Government Relations Committee; and,

Ms Liliane Le Saux was appointed Chairman of the Council on Student Affairs.

44. President's Activities

A schedule of activities of the President is appended for information.

APPENDIX V

45. Council Reports

Executive Council has reviewed Council reports as appended, and matters requiring Board action are included therein.

Respectfully submitted,



Bradley W. Holmes, D.D.S.
Chairman - Executive Council

ADOPTION OF REPORT:

The Board of Governors accepts the report of the Executive Council with appreciation.

CANADIAN DENTAL ASSOCIATION

FINANCIAL STATEMENTS

DECEMBER 31, 1985

McCAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS / COMPTABLES AGRÉÉS

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.ADMIN., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

AUDITORS' REPORT

To the Members,
Canadian Dental Association.

We have examined the balance sheet of the Canadian Dental Association as at December 31, 1985 and the statements of equity, revenue and expenses, revenue and expenses and equity for the Library Trust Fund and the Grieve Memorial Lectureship Fund and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Association as at December 31, 1985 and the results of its operations and the changes in its financial position for the year then ended in accordance with generally accepted accounting principles, except as disclosed in note 1(b), applied on a basis consistent with that of the preceding year.

Chartered Accountants.

Ottawa, Ontario,
February 5, 1986.

Canadian Dental Association
Supplementary notes to the Financial Statements

BALANCE SHEET

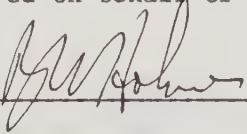
PAGE 1

CASH/	Includes \$ 767,729 General account 200 Petty Cash 10,107 US \$ Account
CASH/ BUILDING FUND	\$ 20,000 was transferred from 1984 surplus increasing fund to over \$40,000. Capitalized expenses during the 1985 year depleted the fund by: \$8460 Garage floor resurface, \$9550 Roof repair/ South East side.
CASH/ TERM DEPOSIT	\$750,000 invested in TD Mortgage GIC at 10.1%; Due April, 1986
ACCOUNTS RECEIVABLE	\$56,661 Journal advertising \$94,108 General Receivables Includes \$57,047 bequest receivable from Gollop Estate plus other year end accruals for incoming receipts such as 1985 membership fees, translation grant from Government re Convention expense and monthly invoicing.
INVENTORY	Amount includes Past Presidents pins inventory of \$5139. The balance is pamphlet inventory.
PREPAID EXPENSES	\$ 732 Travel advances 4,440 1986 Insurance paid in 1985. 46,366 Prepaid expenses includes \$14,608 1986 membership expense, \$14,199 1986 NDHM expense plus identifiable 1986 expense for postage, equipment rental, supplies.etc. <u>12,468</u> 1986 Convention expense. \$64,006
PREPAID EXPENSE/ TRUST	\$5300 Library periodical subscriptions paid in 1985 for 1986 year.
DEFERRED REVENUE	1986 Receipts received in 1985 - includes \$459,100 Ontario fees, \$191,816 Quebec Fees, \$19,041 DAT fees plus prepaid subscriptions, prepaid classified advertising and other misc. receipts totaling \$26,683.
MORTGAGE	Current portion of long term debt reflects increase in mortgage debt; monthly payments now \$2262.50 against principle.
TRUST EQUITY	Increase in equity/ Grieve Memorial Trust Fund is due to CDA not requiring use of interest for the past two years to defray the cost of lectureship.

CANADIAN DENTAL ASSOCIATION

BALANCE SHEET

AS AT DECEMBER 31, 1985

	ASSETS	1985	1984
CURRENT			
Cash		\$ 778,036	\$ 826,513
Cash - Building Contingency Fund		25,445	20,883
Deposit certificate		750,000	750,000
Accounts receivable		150,769	74,710
Inventory (note 1)		49,457	54,706
Prepaid expenses		64,006	50,125
		<u>1,817,713</u>	<u>1,776,937</u>
FIXED (notes 1 and 2)		<u>1,379,134</u>	<u>1,413,977</u>
		<u>3,196,847</u>	<u>3,190,914</u>
	TRUST ASSETS		
Cash		52,703	58,313
Accounts receivable		1,276	-
Prepaid expenses		5,300	3,852
Library books and furniture (at nominal value)		<u>1</u>	<u>1</u>
		<u>59,280</u>	<u>62,166</u>
		<u>\$3,256,127</u>	<u>\$3,253,080</u>
	LIABILITIES		
CURRENT			
Accounts payable		\$ 147,095	\$ 129,440
Deferred revenue		696,640	506,018
Current portion of long term debt		<u>27,150</u>	<u>18,000</u>
		<u>870,885</u>	<u>653,458</u>
LONG-TERM DEBT (note 3)		<u>495,487</u>	<u>386,387</u>
		<u>1,366,372</u>	<u>1,039,845</u>
	EQUITY		
SURPLUS		973,978	1,141,479
EQUITY IN FIXED ASSETS (note 4)		<u>856,497</u>	<u>1,009,590</u>
		<u>1,830,475</u>	<u>2,151,069</u>
		<u>3,196,847</u>	<u>3,190,914</u>
	TRUST EQUITY		
Library Trust Fund		51,533	54,964
The Grieve Memorial Lectureship Fund		<u>7,747</u>	<u>7,202</u>
		<u>59,280</u>	<u>62,166</u>
		<u>\$3,256,127</u>	<u>\$3,253,080</u>
Approved on behalf of the Board:			
			
President			
			
Executive Director			

CANADIAN DENTAL ASSOCIATION

STATEMENT OF EQUITY

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>	<u>1984</u>
SURPLUS		
BALANCE - BEGINNING OF YEAR	\$1,141,479	\$1,018,887
Excess of revenue over expenses (expenses over revenue) for the year	(311,594)	251,369
Transfer from (to) equity in fixed assets	153,093 (	128,777)
Transfer of bequest to Canadian Dental Research Foundation	(<u>9,000</u>)	<u>-</u>
BALANCE - END OF YEAR	\$ <u>973,978</u>	\$ <u>1,141,479</u>
EQUITY IN FIXED ASSETS		
BALANCE - BEGINNING OF YEAR	\$1,009,590	\$ 880,813
Transfer from (to) surplus	(<u>153,093</u>)	<u>128,777</u>
BALANCE - END OF YEAR	\$ <u>856,497</u>	\$ <u>1,009,590</u>

Canadian Dental Association
Supplementary notes to the Financial Statements

REVENUE / EXPENSE

PAGE 3

REVENUE:

GRANTS \$15,000 Accreditation grant from NDEB balance is from CFDE for Student conference.
PUBLICATIONS Received from sale of pamphlets.
INTEREST \$ 78,343 Current Accounts interest
61,620 Term Deposit interest
RENTAL Underbudget amount mainly due to vacant space.

EXPENSE:

PER DIEMS \$ 64,000 Honoraria; \$24,000 increase due to 1985 rates.
216,906 Per Diems; \$55,129 increase due to 1985 rates.
9,155 includes \$4,500 unaccountable expense paid plus CDA portion of CPP payments on Per Diems
\$290,061

SALARIES Amount includes settlement and salary adjustments made re termination of previous Executive Director and increased use of temporary staff due to workloads requirements.

CONVENTION Complete breakout of Revenue and Expense is appended for information

CONFERENCES Understated due to timing - Annual teaching conference for 1985 was held in January, 1986. This budget item will be overbudget in 1986.

DATP Increase in expense more than compensated by increase in revenue. (Page 9)

MEMBERSHIP Increase reflects upgrade of CDA Display booth at \$3,000 and approx. \$7,000 for first class mailing of December Journal to non-members, plus \$5,000 for a second Journal mailing in May.

STUDENTS 1985 is first year of total allocation of student expense to separate accounts.

FDI ADMIN Change in accounting practice: 1984 actuals show expense against netted receivables, \$13,889 / \$2426 or \$11,463 CDA expense, 1985 actuals show expense against total revenue \$29,679 / \$16,740 or \$12,939 CDA expense. Amount includes CDAs' FDI membership fee.

CONSULTING \$ 41,930 Ray Rouse Communications/ Strategic Planning
8,472 McMillan, Binch / Professional Management Cos.
6,407 Cowling, Henderson/ Dental Therapy
2,521 McCarthy & McCarthy/ Dental Therapy
2,201 Manifest Communications/ Product Recognition
1,760 Pye, Richards/ Preparation of parking expansion
395 Mr. G. Spark/ Professional Journal review.
\$ 63,686

DENTAL AWARENESS	Budget	Actual	1984
Dental Health Month	\$ 75,000	\$ 97,188	\$ 68,809
Consultants	200,000	254,619	73,927
Administration	30,000	28,028	4,230

Further breakdown of the Dental Awareness Program expense is appended.

CANADIAN DENTAL ASSOCIATION
STATEMENT OF REVENUE AND EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 1985

	1985		1984
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
REVENUE			
Fees (page 9)	\$2,194,425	\$2,232,283	\$2,190,815
Grants	30,000	22,515	29,264
Journal (page 10)	426,000	402,492	405,013
Publications	70,000	78,728	70,990
Interest	85,000	139,963	156,543
Rental	178,734	173,539	133,487
Other (page 9)	49,000	140,089	30,052
Convention	-	333,351	-
	<u>3,033,159</u>	<u>3,522,960</u>	<u>3,016,164</u>
EXPENSES			
Honoraria and per diem	265,044	290,061	189,406
Salaries and benefits	661,559	675,981	610,354
General and administration (page 11)	305,050	313,664	300,199
Convention	-	386,109	-
Conferences	22,500	11,154	26,995
Journal (page 10)	554,701	542,710	505,928
Other publications (page 11)	105,330	92,955	88,118
Travel and meetings (page 12)	472,854	491,394	391,776
Unbudgeted projects (page 12)	50,000	64,314	38,036
Property management	282,929	253,427	241,266
Dental Awareness and DHM	305,000	379,835	146,966
Accreditation surveys	50,000	58,036	32,814
Dental Aptitude Program	79,700	83,972	80,524
Membership campaign	35,515	35,309	27,634
Student affairs	33,500	31,413	17,394
Library	14,900	19,355	10,346
F.D.I. administration	20,000	29,679	13,889
Consulting fees	57,500	63,686	37,756
Grants and sponsorships	12,000	11,500	5,394
	<u>3,328,082</u>	<u>3,834,554</u>	<u>2,764,795</u>
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE) FOR THE YEAR	(\$ 294,923)	(\$ 311,594)	\$ 251,369

CANADIAN DENTAL ASSOCIATION

LIBRARY TRUST FUND

STATEMENT OF REVENUE AND EXPENSES AND EQUITY

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>	<u>1984</u>
REVENUE		
Interest	\$ 3,662	\$ 4,525
Donations	<u>2,011</u>	<u>200</u>
	5,673	4,725
EXPENSES		
Books	1,378	2,807
Miscellaneous	214	38
Subscriptions	<u>7,512</u>	<u>3,082</u>
	<u>9,104</u>	<u>5,927</u>
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE) FOR THE YEAR	(3,431)	(1,202)
Equity - beginning of year	<u>54,964</u>	<u>56,166</u>
EQUITY - END OF YEAR	<u>\$51,533</u>	<u>\$54,964</u>

CANADIAN DENTAL ASSOCIATION
THE GRIEVE MEMORIAL LECTURESHIP FUND
STATEMENT OF REVENUE AND EXPENSES AND EQUITY
FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>	<u>1984</u>
REVENUE		
Interest	\$ 545	\$ 625
EXPENSES		
EXCESS OF REVENUE OVER EXPENSES FOR THE YEAR	545	625
Equity - beginning of year	<u>7,202</u>	<u>6,577</u>
EQUITY - END OF YEAR	<u>\$7,747</u>	<u>\$7,202</u>

CANADIAN DENTAL ASSOCIATION
STATEMENT OF CHANGES IN FINANCIAL POSITION
FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>	<u>1984</u>
SOURCE OF FUNDS		
Operations		
Excess of revenue over expenses for the year	\$ -	\$ 251,369
Item not requiring working capital - depreciation	<u>-</u>	<u>72,483</u>
	-	323,852
Increase in long-term debt	<u>109,100</u>	<u>-</u>
	109,100	323,852
APPLICATION OF FUNDS		
Operations		
Excess of expenses over revenue for the year	311,594	-
Item not requiring working capital - depreciation	(<u>78,060</u>)	<u>-</u>
	233,534	-
Purchase of fixed assets	43,217	183,260
Reduction of long-term debt	-	18,000
Transfer of bequest to Canadian Dental Research Foundation	<u>9,000</u>	<u>-</u>
	<u>285,751</u>	<u>201,260</u>
INCREASE (DECREASE) IN WORKING CAPITAL	(176,651)	122,592
Working capital - beginning of year	<u>1,123,479</u>	<u>1,000,887</u>
WORKING CAPITAL - END OF YEAR	<u>\$ 946,828</u>	<u>\$1,123,479</u>

CANADIAN DENTAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1985

1. SIGNIFICANT ACCOUNTING POLICIES

(a) Inventory

Inventory is stated at the lower of cost and net realizable value.

(b) Depreciation

Furniture and equipment purchased subsequent to January 1, 1979 is expensed when acquired. Purchases prior to this date have been fully depreciated.

Depreciation is provided on the straight line basis as follows:

Building	- 40 years
Building improvements	- 5 years
Data processing equipment	- 5 years

(c) Revenue Recognition

Membership fees and subscriptions to the Journal are recognized as revenue in the year to which they apply.

2. FIXED ASSETS

	1985			1984
	Cost	Accumulated Depreciation	Net	Net
Land	\$ 82,915	\$ -	\$ 82,915	\$ 82,915
Building	1,543,034	344,942	1,198,092	1,223,944
Building improvements	110,928	78,181	32,747	19,740
Furniture and equipment	75,769	75,768	1	1
Data processing equipment	109,988	57,149	52,839	74,837
Chain of office	12,540	-	12,540	12,540
	<u>\$1,935,174</u>	<u>\$556,040</u>	<u>\$1,379,134</u>	<u>\$1,413,977</u>

CANADIAN DENTAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1985

3. LONG-TERM DEBT

	<u>1985</u>	<u>1984</u>
Mortgage	\$ 522,637	\$ 404,387
Current portion	<u>27,150</u>	<u>18,000</u>
	<u>\$ 495,487</u>	<u>\$ 386,387</u>

The mortgage on the building with Toronto Dominion Bank bears interest at bank prime rate and is repayable in monthly instalments of \$2,262 plus interest, maturing March, 2005.

4. EQUITY IN FIXED ASSETS

	<u>1985</u>	<u>1984</u>
Balance - beginning of year	\$1,009,590	\$ 880,813
Additions to fixed assets	43,217	183,260
Mortgage reduction (increase)	(118,250)	18,000
Depreciation	(<u>78,060</u>)	(<u>72,483</u>)
	(<u>153,093</u>)	<u>128,777</u>
Balance - end of year	<u>\$ 856,497</u>	<u>\$1,009,590</u>

5. COMMITMENT

The Association is committed to the balance of the Dental Awareness Program which will result in expenditures in 1986 of approximately \$135,000.

6. COMPARATIVE FIGURES

Certain comparative figures have been reclassified to conform with current presentation.

CANADIAN DENTAL ASSOCIATION

SCHEDULE OF FEE REVENUE

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
Active and affiliate	\$1,872,450	\$1,874,917	\$1,854,498
Associate	10,080	7,209	10,902
Student	24,700	28,215	26,967
Corporate	144,695	144,546	140,412
D.A.T. Program	126,000	151,146	131,936
Accreditation Program	16,500	26,250	26,100
	<u>\$2,194,425</u>	<u>\$2,232,283</u>	<u>\$2,190,815</u>

SCHEDULE OF OTHER REVENUE

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
FDI	\$ 14,000	\$ 16,740	\$ 2,426
Foreign exchange	-	7,338	-
Dental Health Month	20,000	22,700	19,170
Unallocated	-	12,264	1,456
Product acceptance	15,000	15,000	7,000
Bequest - Gollop Estate	-	66,047	-
	<u>\$ 49,000</u>	<u>\$ 140,089</u>	<u>\$ 30,052</u>

CANADIAN DENTAL ASSOCIATION
 SCHEDULE OF JOURNAL OPERATIONS
 FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
REVENUE			
Advertising	\$410,000	\$387,509	\$386,752
Subscriptions	15,000	14,639	15,377
Reprints	<u>1,000</u>	<u>344</u>	<u>2,884</u>
	426,000	402,492	405,013
EXPENSES			
Agency commission	68,610	57,906	58,084
Salaries and benefits	106,391	101,323	83,040
Production	290,000	302,542	270,720
Shipping	18,000	13,619	18,048
Postage	12,000	10,628	9,676
Travel	6,000	8,091	9,605
Translation	20,000	18,351	20,097
Promotion	13,500	13,674	18,413
Circulation audit	1,200	1,192	1,105
Reprints	1,000	1,827	3,142
Scientific editors	8,000	8,068	6,700
Telephone	5,000	5,109	5,177
Bad debts	<u>5,000</u>	<u>380</u>	<u>2,121</u>
	<u>554,701</u>	<u>542,710</u>	<u>505,928</u>
EXCESS OF REVENUE OVER EXPENSES (EXPENSES OVER REVENUE) FOR THE YEAR	<u>(\$128,701)</u>	<u>(\$140,218)</u>	<u>(\$100,915)</u>

Canadian Dental Association
Supplementary notes to the Financial Statements

GENERAL AND ADMINISTRATION

PAGE 11

OFFICE

EQUIPMENT

Amount includes purchase of four electronic typewriters, installation of diving screening in the first floor office area, equipment rentals and maintenance, and minor office furniture purchases.

PROFESSIONAL

FEES

Includes \$7,800 for annual audit and \$4,526 legal expense.

GENERAL

Amalgamation of accounts for membership subscriptions, photography expense, administration charges, CDSPI insurance coverage for Executive Council members, Misc. office expense, etc. Small amount accounts requiring further consideration re grouping for presentation due to new budget layout. Highest amount of \$7115 for Misc. office expense covers coffee supplies for meetings and staff, licenses and filing fees, Christmas expenses, floral tributes, business gifts, etc.

CANADIAN DENTAL ASSOCIATION

SCHEDULE OF GENERAL AND ADMINISTRATION EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
Office equipment	\$ 50,000	\$ 42,633	\$ 37,086
Insurance	10,200	10,271	9,751
Stationery and supplies	22,000	20,266	23,025
Postage	50,000	52,364	37,509
Shipping and delivery	4,400	3,395	4,658
Telephone	59,000	64,965	59,468
Translation	11,000	13,318	16,911
Data processing	36,780	40,911	35,542
Printing	42,000	40,994	50,251
Professional fees	13,000	12,326	10,964
General	6,670	12,221	15,034
	<u>\$305,050</u>	<u>\$313,664</u>	<u>\$300,199</u>

SCHEDULE OF OTHER PUBLICATIONS EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Actual</u>	<u>Actual</u>
Pamphlets	\$ 70,000	\$ 61,489	\$ 61,434
Film distribution program	5,500	2,258	4,063
Communique	28,000	27,859	20,789
Press clippings	1,830	1,349	1,832
	<u>\$105,330</u>	<u>\$ 92,955</u>	<u>\$ 88,118</u>

Canadian Dental Association
Supplementary notes to the Financial Statements

TRAVEL AND MEETINGS

PAGE 12

EXECUTIVE COUNCIL COMMITTEES

Membership Committee budget was for two meetings; only one was held. Taxation Committee expense underbudget due to committee members incorporating committee needs with other necessary travel expense. Liaison/ Convention includes Executive Council members attendance at Annual Convention, liaison with CDSPI, and attendance by Executive Council members to other than CDA meetings.

EDUCATION COUNCILS AND COMMITTEES

	BUDGET	ACTUALS	1984
Education and Accreditation			
includes sub Comm. action	\$ 23,565	\$ 54,268	\$ 22,294
DATP and Chalk Grading	37,000	26,615	27,978
Continuing Education	<u>6,000</u>	<u>7,110</u>	<u>2,045</u>
TOTALS	\$ 66,565	\$ 87,993	\$ 52,317

Education Council meeting and Chairmans' expense amounted to \$30,193. Balance of \$24,075 includes expense for Ad Hoc Committee work on Competency Profiles, Reciprocity, Documentation and Prelicensure.

UNBUDGETED PROJECTS

Manpower Study and Symposium line shows Manpower study costs, 1984, and Manpower Symposium cost, 1985. Symposium expense includes \$12,886, Speakers and Participants; \$3,476, Food & Beverage; \$8,150, CDA representatives; \$768, Administration cost. Revenue of \$1,025 was netted against this expense of \$25,280 leaving a balance of \$24,255.

Pre-selection CEO: Amount includes \$ 22,000 for Price, Waterhouse professional services; expense of preselection committee meeting and expense of Management Committee members meetings with Price, Waterhouse.

Health Care: Expense for representation at National Advisory Committee on AIDS; Intra Association meeting with Health Protection Branch; and, Chairmans' expense re Ad Hoc Committee / Health Care Councils' terms of reference.

CANADIAN DENTAL ASSOCIATION

SCHEDULE OF TRAVEL AND MEETINGS EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1985

	1985		1984
	Budget	Actual	Actual
Board of Governors	\$ 66,000	\$ 57,491	\$ 60,395
Executive Council:			
Executive Council	39,420	41,944	32,945
Management Committee	35,148	33,004	29,204
Product Acceptance	9,486	7,001	5,003
Membership Committee	10,670	4,801	5,433
Taxation Committee	2,265	304	3,225
President's Expense	52,535	46,723	49,375
Editorial Board	6,750	7,747	9,213
Liaison/convention	10,000	15,024	7,003
Salaried Dentists	-	1,419	2,690
Council on Dental Materials and Devices	15,300	11,347	9,831
Council on Education	66,565	87,993	52,317
Council on Ethics	5,000	3,138	1,741
Council on Health Care	22,110	21,104	16,003
Council on Hospital Services	9,560	8,927	9,602
Council on Student Affairs	16,000	11,797	13,480
Council on Information Services	19,710	14,533	13,308
Council on Constitution and By-laws	5,000	-	4,231
F.D.I. Congress	-	16,084	-
Secretaries Conference	-	1,740	-
Third party payment plans	13,950	19,309	-
Joint Advisory	-	3,380	-
	405,469	414,810	324,999
Staff travel	54,500	64,307	55,077
President's and Chief Executive Officer's meeting	9,000	8,392	8,095
Specialty Sections	3,885	3,885	3,605
	<u>\$472,854</u>	<u>\$491,394</u>	<u>\$391,776</u>
UNBUDGETED PROJECTS			
Manpower Study and Symposium		\$ 24,255	\$ 6,724
Ad Hoc Committees:			
Hospital Services		-	4,615
Prepaid Dental Plans		-	6,775
Licensure and Documentation		3,549	6,439
Health Care		2,380	-
Pre-selection Executive Director		29,067	-
Native and Inuit group		2,776	-
Remuneration		2,287	-
Membership workshop		-	13,483
	<u>\$ 50,000</u>	<u>\$ 64,314</u>	<u>\$ 38,036</u>

CANADIAN DENTAL ASSOCIATION

1985 CONVENTION ACCOUNTS AS AT 31 DECEMBER, 1985

CONVENTION REVENUE

ACCOUNT	AMOUNT	BUDGET
EXHIBITION BOOTHS	\$120,101	\$112,000
EARLY REGISTRATION	\$69,495	\$168,000
LATE REGISTRATION	\$68,894	\$50,000
EARLY REGISTRATION/ CDAA	\$1,150	
LATE REGISTRATION / CDAA	\$1,893	\$24,000
EARLY REGISTRATION / CDHA	\$2,398	
LATE REGISTRATION / CDHA	\$888	
SPOUSES REGISTRATION	\$29,348	\$33,000
SUNDAY AFTERNOON RECEPTION	\$420	\$20,000
SUNDAY REGISTRATION PARTY	\$7,420	
BYTOWN BASH	\$2,630	
FUN RUN	\$176	
PRESIDENTS' BALL	\$12,016	
SCIENTIFIC PROGRAM	\$7,600	
OTHER	\$4,554	
PRE CONVENTION COURSES	\$9,074	
CASINO CABARET	\$453	
INTEREST	\$0	\$12,000
REFUNDS	(\$5,159)	
TOTAL	\$333,351	\$419,000

CONVENTION EXPENSE

SCIENTIFIC PROGRAMS	\$34,923	\$45,000
SUNDAY AFTERNOON RECEPTION	\$2,440	\$2,440
SUNDAY REGISTRATION PARTY	\$31,360	\$27,800
BYTOWN BASH	\$37,746	\$44,500
PRESIDENTS' BALL	\$4,342	\$26,800
MEALS	\$64,287	\$49,500
HOST	\$0	\$2,000
EXHIBITS	\$16,782	\$17,500
ADMINISTRATION	\$66,031	\$50,000
MAILING	\$7,486	\$15,000
PROMOTION	\$40,076	\$50,000
SUNDRY	\$4,388	\$10,000
RENTAL - CONGRESS CENTRE	\$32,797	\$27,035
LOCAL ARRANGEMENTS	\$19,304	\$17,000
SPOUSES PROGRAM	\$24,147	\$27,920
TOTAL	\$386,109	\$412,495

NET SURPLUS/ DEFICIT	(\$52,758)	\$6,505
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NOTE: 1) Accounting reviewed the years' revenue and expense and prepared a schedule to allocated possible interest earned on net monthly revenues. As separate accounts were not allocated until well into the 1985 year a positive amount was not verified. The conclusion arrived at was that over the months \$6,000 was earned on net revenue/ Expense.

2) All activity recorded through the US funds account for 1985 was not recorded to specific accounts. A further amount of approximately \$6,000 recorded as Unallocated Revenue should be considered as Convention revenue.

CANADIAN DENTAL ASSOCIATION
DENTAL AWARENESS PROGRAM

	DHM	BUDGET	MANIFEST	BUDGET	ADMIN EXP	BUDGET
1984 EXPENSE	\$68,809	\$45,000	\$41,193	\$42,000	\$4,230	
1985 EXPENSE	\$97,188	\$75,000	\$254,619	\$200,000	\$28,028	\$30,000
1986 BUDGET		\$75,000		\$148,500		\$24,000
TOTAL PROGRAM EXPENSE			\$295,812	\$390,500	\$32,258	

DHM AND Media Training
workshops revenue, 1985 \$22,700

PROGRAM EXPENSE ANALYSIS 1985

MATERIALS	\$53,723
DHM TRAINING	\$6,565
PROV INFO KITS	\$24,345
GOOD FOR LIFE KITS	\$7,281
DHM SUPPLEMENT	\$3,949
DHM / COMMUNIQUE	\$1,325

Total DHM \$97,188

SHIP/POST	\$4,445
TRANSLATION	\$6,951
MEETING EXP	\$3,907
APRIL 1ST RECPT	\$3,835
1984 EXP RECORDED '85	\$3,270
MISC: artwork, photos, equip rental, press releases, etc.	\$5,620

Total CDA Admin expense \$28,028

MANIFEST BREAKDOWN

Consultants fees	\$140,040
Travel	\$12,731
Training	\$5,092
Other	\$96,756

Total Manifest \$254,619

Breakdown of Other:

Admin	\$12,578
Press Clippings	\$2,903
Markup @15%	\$14,513
Reimbursable cost	\$66,762

Total \$96,756

Administration expense includes storage, photocopy,
and shipping/postage expense.

Press Clippings expense covers newspaper monitoring expense
and preparation of materials for CDA clippings service.

Reimbursable costs include materials preparation
(artwork, layout, printing, etc.) for media
information kits, training materials, report production
and research expense for "Public Attitudes Report" and
for participation in Gallup National Omnibus.

ASSOCIATION DENTAIRE CANADIENNE

ETATS FINANCIERS

LE 31 DECEMBRE 1985

McCAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS / COMPTABLES AGRÉÉS

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.A.D.M.I.N., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

RAPPORT DES VERIFICATEURS

Aux membres de
l'Association Dentaire
Canadienne

Nous avons vérifié le bilan de l'Association Dentaire Canadienne au 31 décembre 1985 ainsi que les états de l'avoir et des résultats, de l'avoir et des résultats du fonds en fiducie pour la bibliothèque et du fonds "Grieve Memorial Lectureship" et de l'évolution de la situation financière de l'exercice terminé à cette date. Notre vérification a été effectuée conformément aux normes de vérification généralement reconnues, et a comporté par conséquent les sondages et autres procédés que nous avons jugés nécessaires dans les circonstances.

A notre avis, ces états financiers présentent fidèlement la situation financière de l'Association au 31 décembre 1985 ainsi que les résultats de son exploitation et l'évolution de sa situation financière pour l'exercice terminé à cette date selon les principes comptables généralement reconnus à l'exception du principe décrit à la note 1(b), appliqués de la même manière qu'au cours de l'exercice précédent.

Comptables agréés

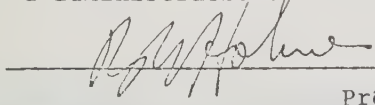
Ottawa, Ontario,
le 5 février 1986.

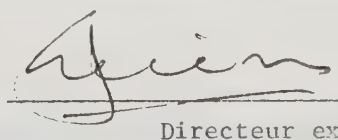
BILAN

AU 31 DECEMBRE 1985

	ACTIF	1985	1984
ACTIF A COURT TERME			
Encaisse		\$ 778,036	\$ 826,513
Encaisse - Fonds pour éventualités (bâtiment)		25,445	20,883
Certificat de dépôt		750,000	750,000
Comptes à recevoir		150,769	74,710
Stocks (note 1)		49,457	54,706
Frais payés d'avance		64,006	50,125
		<u>1,817,713</u>	<u>1,776,937</u>
ACTIF IMMOBILISE (notes 1 et 2)		<u>1,379,134</u>	<u>1,413,977</u>
		<u>3,196,847</u>	<u>3,190,914</u>
ACTIF DU FONDS EN FIDUCIE			
Encaisse		52,703	58,313
Obligations et certificat de dépôt		1,276	-
Frais payés d'avance		5,300	3,852
Livres de bibliothèque et mobilier (à la valeur nominale)		<u>1</u>	<u>1</u>
		<u>59,280</u>	<u>62,166</u>
		<u>\$3,256,127</u>	<u>\$3,253,080</u>
	PASSIF		
PASSIF A COURT TERME			
Comptes à payer		\$ 147,095	\$ 129,440
Revenu reporté		696,640	506,018
Partie courante de la dette à long terme		<u>27,150</u>	<u>18,000</u>
		<u>870,885</u>	<u>653,458</u>
DETTE A LONG TERME (note 3)		<u>495,487</u>	<u>386,387</u>
		<u>1,366,372</u>	<u>1,039,845</u>
	AVOIR		
SURPLUS		973,978	1,141,479
AVOIR EN ACTIF IMMOBILISE (note 4)		<u>856,497</u>	<u>1,009,590</u>
		<u>1,830,475</u>	<u>2,151,069</u>
		<u>3,196,847</u>	<u>3,190,914</u>
AVOIR DU FONDS EN FIDUCIE			
Fonds en fiducie pour la bibliothèque		51,533	54,964
Fonds en fiducie "Grieve Memorial Lectureship"		<u>7,747</u>	<u>7,202</u>
		<u>59,280</u>	<u>62,166</u>
		<u>\$3,256,127</u>	<u>\$3,253,080</u>

Approuvé au nom du conseil
d'administration:


Président


Directeur exécutif

ASSOCIATION DENTAIRE CANADIENNE

ETAT DE L'AVOIR

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>	<u>1984</u>
SURPLUS		
SOLDE AU DEBUT DE L'EXERCICE	\$1,141,479	\$1,018,887
Excédent des revenus sur les dépenses (dépenses sur les revenus) pour l'exercice	(311,594)	251,369
Virement de (à) l'avoir en actif immobilisé	153,093	(128,777)
Virement de legs à la Fondation Canadienne de Recherches Dentaires	(<u>9,000</u>)	<u>-</u>
SOLDE A LA FIN DE L'EXERCICE	\$ <u>973,978</u>	\$ <u>1,141,479</u>
AVOIR EN ACTIF IMMOBILISE		
SOLDE AU DEBUT DE L'EXERCICE	\$1,009,590	\$ 880,813
Virement du (au) surplus	(<u>153,093</u>)	<u>128,777</u>
SOLDE A LA FIN DE L'EXERCICE	\$ <u>856,497</u>	\$ <u>1,009,590</u>

ASSOCIATION DENTAIRE CANADIENNE

ETAT DES RESULTATS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Réel</u>	<u>Réel</u>
REVENUS			
Cotisations (page 9)	\$2,194,425	\$2,232,283	\$2,190,815
Subventions	30,000	22,515	29,264
Journal (page 10)	426,000	402,492	405,013
Publications	70,000	78,728	70,990
Intérêts	85,000	139,963	156,543
Location	178,734	173,539	133,487
Autres (page 9)	49,000	140,089	30,052
Assemblée annuelle	-	333,351	-
	<u>3,033,159</u>	<u>3,522,960</u>	<u>3,016,164</u>
DEPENSES			
Honoraires et indemnités	265,044	290,061	189,406
Salaires et bénéfices	661,559	675,981	610,354
Générales et administratives (page 11)	305,050	313,664	300,199
Assemblée annuelle	-	386,109	-
Conférences	22,500	11,154	26,995
Journal (page 10)	554,701	542,710	505,928
Autres publications (page 11)	105,330	92,955	88,118
Voyages et réunions (page 12)	472,854	491,394	391,776
Projets non budgétisés (page 12)	50,000	64,314	38,036
Gestion d'immeubles	282,929	253,427	241,266
Sensibilisation et le mois de la santé dentaire	305,000	379,835	146,966
Les visites d'agrément	50,000	58,036	32,814
Le programme du test d'aptitudes dentaires	79,700	83,972	80,524
Campagne pour nouveaux membres	35,515	35,309	27,634
Affaires des étudiants	33,500	31,413	17,394
Bibliothèque	14,900	19,355	10,346
Administration de F.D.I.	20,000	29,679	13,889
Frais de consultation	57,500	63,686	37,756
Subventions et parrainages	12,000	11,500	5,394
	<u>3,328,082</u>	<u>3,834,554</u>	<u>2,764,795</u>
EXCEDENT DES REVENUS SUR LES DEPENSES (DEPENSES SUR LES REVENUS) POUR L'EXERCICE	(\$ 294,923)	(\$ 311,594)	\$ 251,369

ASSOCIATION DENTAIRE CANADIENNE

FONDS EN FIDUCIE POUR LA BIBLIOTHEQUE

ETAT DE L'AVOIR ET DES RESULTATS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>	<u>1984</u>
REVENUS		
Intérêts	\$ 3,662	\$ 4,525
Dons	<u>2,011</u>	<u>200</u>
	5,673	4,725
DEPENSES		
Livres	1,378	2,807
Divers	214	38
Abonnements	<u>7,512</u>	<u>3,082</u>
	<u>9,104</u>	<u>5,927</u>
EXCEDENT DES REVENUS SUR LES DEPENSES (DEPENSES SUR LES REVENUS) POUR L'EXERCICE	(3,431)	(1,202)
Avoir au début de l'exercice	<u>54,964</u>	<u>56,166</u>
AVOIR A LA FIN DE L'EXERCICE	<u>\$51,533</u>	<u>\$54,964</u>

ASSOCIATION DENTAIRE CANADIENNE
FONDS "GRIEVE MEMORIAL LECTURESHIP"
ETAT DES RESULTATS ET DE L'AVOIR
POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>	<u>1984</u>
REVENU		
Intérêts	\$ 545	\$ 625
DEPENSE -	<u>-</u>	<u>-</u>
EXCEDENT DU REVENU SUR LA DEPENSE POUR L'EXERCICE	545	625
Avoir au début de l'exercice	<u>7,202</u>	<u>6,577</u>
AVOIR A LA FIN DE L'EXERCICE	<u>\$7,747</u>	<u>\$7,202</u>

ASSOCIATION DENTAIRE CANADIENNE

ETAT DE L'EVOLUTION DE LA SITUATION FINANCIERE

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>	<u>1984</u>
PROVENANCE DU FONDS DE ROULEMENT		
Fonds provenant de l'exploitation		
Excédent des revenus sur les dépenses pour l'exercice	\$ -	\$ 251,369
Elément n'affectant pas le fonds de roulement - amortissement	<u>-</u>	<u>72,483</u>
	-	323,852
Augmentation de la dette à long terme	<u>109,100</u>	<u>-</u>
	109,100	323,852
UTILISATION DU FONDS DE ROULEMENT		
Fonds utilisés dans l'exploitation		
Excédent des dépenses sur les revenus pour l'exercice	311,594	-
Elément n'affectant pas le fonds de roulement - amortissement	(<u>78,060</u>)	<u>-</u>
	233,534	-
Acquisition d'actif immobilisé	43,217	183,260
Diminution de la dette à long terme	-	18,000
Virement de legs à la Fondation Canadienne de Recherches Dentaires	<u>9,000</u>	<u>-</u>
	<u>285,751</u>	<u>201,260</u>
AUGMENTATION (DIMINUTION) DU FONDS DE ROULEMENT	(176,651)	122,592
Fonds de roulement au début de l'exercice	<u>1,123,479</u>	<u>1,000,887</u>
FONDS DE ROULEMENT A LA FIN DE L'EXERCICE	<u>\$ 946,828</u>	<u>\$1,123,479</u>

ASSOCIATION DENTAIRE CANADIENNE

NOTES COMPLEMENTAIRES

31 DECEMBRE 1985

1. PRINCIPALES CONVENTIONS COMPTABLES

(a) Stocks

Les stocks sont évalués au moindre du coût et de la valeur de réalisation nette.

(b) Amortissement

L'achat de mobilier et d'équipement après le premier janvier 1979 est imputé aux résultats de l'exercice. Les acquisitions après cette date ont été complètement amortis.

L'actif immobilisé est amorti selon la méthode linéaire comme suit:

Immeubles	- 40 ans
Améliorations locatives	- 5 ans
Équipement pour traitement de l'information	- 5 ans

(c) Réalisation des revenus

Les revenus de cotisations et d'abonnements sont comptabilisés sur une base d'exercice tandis que les subventions sont comptabilisées sur une base de caisse.

2. ACTIF IMMOBILISE

	1985			1984
	Coût	Amortissement accumulé	Net	Net
Terrain	\$ 82,915	\$ -	\$ 82,915	\$ 82,915
Immeubles	1,543,034	344,942	1,198,092	1,223,944
Améliorations locatives	110,928	78,181	32,747	19,740
Mobilier et équipement	75,769	75,768	1	1
Équipement pour traitement de l'information	109,988	57,149	52,839	74,837
Chaîne de bureau	12,540	-	12,540	12,540
	<u>\$1,935,174</u>	<u>\$556,040</u>	<u>\$1,379,134</u>	<u>\$1,413,977</u>

ASSOCIATION DENTAIRE CANADIENNE

NOTES COMPLEMENTAIRES

31 DECEMBRE 1985

3. DETTE A LONG TERME

	<u>1985</u>	<u>1984</u>
Hypothèque	\$ 522,637	\$ 404,387
Partie courante	<u>27,150</u>	<u>18,000</u>
	<u>\$ 495,487</u>	<u>\$ 386,387</u>

L'hypothèque sur l'immeuble avec la Banque Toronto-Dominion porte un taux d'intérêt équivalent au taux préférentiel de la banque, des mensualités de \$2,262 en capital plus les intérêts et arrive à échéance en 2005.

4. AVOIR EN ACTIF IMMOBILISE

	<u>1985</u>	<u>1984</u>
Solde au début de l'exercice	\$1,009,590	\$ 880,813
Acquisition d'actif immobilisé	43,217	183,260
Diminution (augmentation) de l'hypothèque	(118,250)	18,000
Amortissement	(<u>78,060</u>)	(<u>72,483</u>)
	(<u>153,093</u>)	<u>128,777</u>
Solde à la fin de l'exercice	<u>\$ 856,497</u>	<u>\$1,009,590</u>

5. ENGAGEMENT

Le Conseil s'est engagé pour le solde des fonds pour le programme de sensibilisation à la santé dentaire lequel aura pour effet des déboursés d'environ \$135,000 en 1986.

6. CHIFFRES COMPARATIFS

Certains chiffres de l'exercice précédent ont été regroupés pour fins de présentation comparative.

ASSOCIATION DENTAIRE CANADIENNE

TABLEAU DES COTISATIONS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Réel</u>	<u>Réel</u>
Membres actifs et affiliés	\$1,872,450	\$1,874,917	\$1,854,498
Membres associés	10,080	7,209	10,902
Etudiants	24,700	28,215	26,967
Membres corporatifs	144,695	144,546	140,412
Le programme du test d'aptitudes dentaires	126,000	151,146	131,936
Le programme d'agrément	<u>16,500</u>	<u>26,250</u>	<u>26,100</u>
	<u>\$2,194,425</u>	<u>\$2,232,283</u>	<u>\$2,190,815</u>

TABLEAU DES AUTRES REVENUS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Réel</u>	<u>Réel</u>
FDI	\$ 14,000	\$ 16,740	\$ 2,426
Change sur devises étrangères	-	7,338	-
Le mois de la santé dentaire	20,000	22,700	19,170
Divers	-	12,264	1,456
Acceptation de produits	15,000	15,000	7,000
Legs - Gollop Estate	<u>-</u>	<u>66,047</u>	<u>-</u>
	<u>\$ 49,000</u>	<u>\$ 140,089</u>	<u>\$ 30,052</u>

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

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ASSOCIATION DENTAIRE CANADIENNE

TABLEAU DES DEPENSES GENERALES ET ADMINISTRATIVES

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Réel</u>	<u>Réel</u>
Equipement de bureau	\$ 50,000	\$ 42,633	\$ 37,086
Assurances	10,200	10,271	9,751
Fournitures et papeterie	22,000	20,266	23,025
Timbres	50,000	52,364	37,509
Expédition et livraison	4,400	3,395	4,658
Téléphone	59,000	64,965	59,468
Traduction	11,000	13,318	16,911
Traitement de l'information	36,780	40,911	35,542
Impression	42,000	40,994	50,251
Honoraires professionnels	13,000	12,326	10,964
Générales	<u>6,670</u>	<u>12,221</u>	<u>15,034</u>
	<u>\$305,050</u>	<u>\$313,664</u>	<u>\$300,199</u>

TABLEAU DES DEPENSES DES AUTRES PUBLICATIONS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>		<u>1984</u>
	<u>Budget</u>	<u>Réel</u>	<u>Réel</u>
Pamphlets	\$ 70,000	\$ 61,489	\$ 61,434
Programme de distribution de films	5,500	2,258	4,063
Communiqués	28,000	27,859	20,789
Coupures de presse	<u>1,830</u>	<u>1,349</u>	<u>1,832</u>
	<u>\$105,330</u>	<u>\$ 92,955</u>	<u>\$ 88,118</u>

ASSOCIATION DENTAIRE CANADIENNE

TABLEAU DES DEPENSES DE VOYAGES ET DE REUNIONS

POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	1985		1984
	Budget	Réel	Réel
Conseil d'administration	\$ 66,000	\$ 57,491	\$ 60,395
Conseil exécutif:			
Conseil exécutif	39,420	41,944	32,945
Comité de gestion	35,148	33,004	29,204
Acceptation de produits	9,486	7,001	5,003
Comité d'adhésion	10,670	4,801	5,433
Comité fiscal	2,265	304	3,225
Frais du président	52,535	46,723	49,375
Conseil éditorial	6,750	7,747	9,213
Liaison/assemblée	10,000	15,024	7,003
Dentistes salariés	-	1,419	2,690
Conseil des matériaux et appareils dentaires	15,300	11,347	9,831
Conseil d'éducation	66,565	87,993	52,317
Conseil d'éthique	5,000	3,138	1,741
Conseil de la santé	22,110	21,104	16,003
Conseil des services hospitaliers	9,560	8,927	9,602
Conseil des affaires étudiantes	16,000	11,797	13,480
Conseil d'information	19,710	14,533	13,308
Conseil des statuts et des règlements	5,000	-	4,231
Congrès FDI	-	16,084	-
Conférence de secrétaires	-	1,740	-
Régime de paiement d'un tiers parti	13,950	19,309	-
Conseiller joint	-	3,380	-
	405,469	414,810	324,999
Voyages du personnel	54,500	64,307	55,077
Rencontre des présidents et des officiers en chef	9,000	8,392	8,095
Sections des spécialités	3,885	3,885	3,605
	<u>\$472,854</u>	<u>\$491,394</u>	<u>\$391,776</u>
PROJETS NON BUDGETISES			
Etude de la main-d'oeuvre		\$ 24,255	\$ 6,724
Comités spéciaux:			
Services à l'hôpital		-	4,615
Plans dentaires payés d'avance		-	6,775
Permis provisoires et documentation		3,549	6,439
Soin de la santé		2,380	-
Pré-sélection d'un Directeur exécutif		29,067	-
Groupes d'habitants et d'Inuit		2,776	-
Rémunération		2,287	-
Atelier - membres		-	13,483
	<u>\$ 50,000</u>	<u>\$ 64,314</u>	<u>\$ 38,036</u>

THE CANADIAN DENTAL RESEARCH FOUNDATION
FINANCIAL STATEMENTS
DECEMBER 31, 1985

McCAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS / COMPTABLES AGRÉÉS

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.A.D.M.I.N., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.
CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

AUDITORS' REPORT

To the Members,
The Canadian Dental Research
Foundation.

We have examined the balance sheet of The Canadian Dental Research Foundation as at December 31, 1985 and the statements of current account revenue and expense and surplus and capital account surplus for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Foundation as at December 31, 1985 and the results of its operations for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Chartered Accountants.

Ottawa, Ontario,
January 22, 1986.

THE CANADIAN DENTAL RESEARCH FOUNDATION

BALANCE SHEET

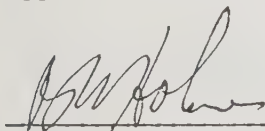
AS AT DECEMBER 31, 1985

	ASSETS	<u>1985</u>	<u>1984</u>
CURRENT ACCOUNT			
Cash		\$16,020	\$ 4,360
Deposit certificate		12,000	12,000
Accrued interest receivable		<u>85</u>	<u>-</u>
		28,105	16,360
CAPITAL ACCOUNT			
Investments, at cost (market value 1985 and 1984 \$11,500)		<u>12,000</u>	<u>12,000</u>
		<u>\$40,105</u>	<u>\$28,360</u>

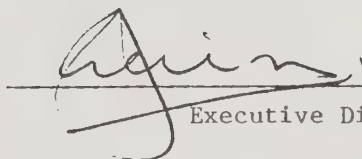
MEMBERS' EQUITY

CURRENT ACCOUNT	\$20,617	\$ 8,872
CAPITAL ACCOUNT	<u>19,488</u>	<u>19,488</u>
	<u>\$40,105</u>	<u>\$28,360</u>

Approved on behalf of the Board:



President



Executive Director

THE CANADIAN DENTAL RESEARCH FOUNDATION
 STATEMENT OF CURRENT ACCOUNT REVENUE AND EXPENSE AND SURPLUS
 FOR THE YEAR ENDED DECEMBER 31, 1985

	<u>1985</u>	<u>1984</u>
REVENUE		
Interest	\$ 3,945	\$ 2,215
EXPENSE		
Annual award	<u>1,200</u>	<u>1,200</u>
EXCESS OF REVENUE OVER EXPENSE FOR THE YEAR	2,745	1,015
Transfer of bequest from Canadian Dental Association	9,000	-
Surplus - beginning of year	<u>8,872</u>	<u>7,857</u>
SURPLUS - END OF YEAR	<u>\$20,617</u>	<u>\$ 8,872</u>

STATEMENT OF CAPITAL ACCOUNT SURPLUS
 FOR THE YEAR ENDED DECEMBER 31, 1985

SURPLUS -- BEGINNING AND END OF YEAR	<u>\$19,488</u>	<u>\$19,488</u>
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THE CANADIAN DENTAL RESEARCH FOUNDATION

SCHEDULE OF INVESTMENTS

AS AT DECEMBER 31, 1985

	<u>Cost</u>
\$7,000 Canada Trust Corporation 11.75% debenture, due April 18, 1987	\$ 7,000
\$5,000 Hydro-Electric Power Commission of Ontario 9% bond, due April 1, 1994	<u>5,000</u>
	<u>\$12,000</u>

LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

ETATS FINANCIERS

LE 31 DECEMBRE 1985

McCAY, DUFF & COMPANY

CHARTERED ACCOUNTANTS / COMPTABLES AGRÉÉS

JOHN W. FRANKLIN, C.A.
THOMAS W. HOWARTH, C.A.
BRYAN E. SULLIVAN, C.A.
ALBERT G. MONSOUR, B.ADMIN., C.A.
BLAIR E. DAVIDSON, B.COMM., C.A.

CONSULTANT - ELDREN E. McCONNELL, C.A.

330 McLEOD ST.
OTTAWA, ONT.
K2P 2C5
(613) 236-2367

RAPPORT DES VERIFICATEURS

Aux membres de
La Fondation Canadienne de
Recherches Dentaires,

Nous avons vérifié le bilan de la Fondation Canadienne de Recherches Dentaires au 31 décembre 1985 ainsi que l'état des résultats et du surplus du compte courant et l'état du surplus du compte capital pour l'exercice terminé à cette date. Notre vérification a été effectuée conformément aux normes de vérification généralement reconnues, et a comporté par conséquent les sondages et autres procédés que nous avons jugés nécessaires dans les circonstances.

A notre avis, ces états financiers présentent fidèlement la situation financière de la Fondation au 31 décembre 1985 ainsi que les résultats de son exploitation pour l'exercice terminé à cette date selon les principes comptables généralement reconnus, appliqués de la même manière qu'au cours de l'exercice précédent.

Comptables agréés

Ottawa, Ontario,
le 22 janvier 1986.

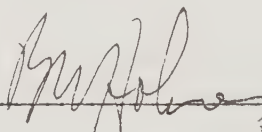
LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

BILAN

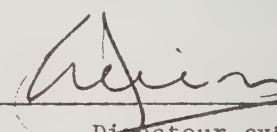
AU 31 DECEMBRE 1985

ACTIF	<u>1985</u>	<u>1984</u>
COMPTE COURANT		
Encaisse	\$16,020	\$ 4,360
Certificats de dépôts	12,000	12,000
Intérêts courus à recevoir	<u>85</u>	<u>-</u>
	28,105	16,360
COMPTE CAPITAL		
Investissements, au coût (valeur du marché \$11,500, 1985 et 1984)	<u>12,000</u>	<u>12,000</u>
	<u>\$40,105</u>	<u>\$28,360</u>
SURPLUS		
COMPTE COURANT	\$20,617	\$ 8,872
COMPTE CAPITAL	<u>19,488</u>	<u>19,488</u>
	<u>\$40,105</u>	<u>\$28,360</u>

Approuvé au nom du conseil d'administration:



 Président



 Directeur exécutif

LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES
 ETAT DES RESULTATS ET DU SURPLUS DU COMPTE COURANT
 POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

	<u>1985</u>	<u>1984</u>
REVENU		
Intérêts	\$ 3,945	\$ 2,215
DEPENSE		
Prix annuel	<u>1,200</u>	<u>1,200</u>
EXCEDANT DU REVENU SUR LA DEPENSE POUR L'EXERCICE	2,745	1,015
Virement de legs de l'Association Dentaire Canadienne	9,000	-
Surplus au début de l'exercice	<u>8,872</u>	<u>7,857</u>
SURPLUS A LA FIN DE L'EXERCICE	<u>\$20,617</u>	<u>\$ 8,872</u>

ETAT DU SURPLUS DU COMPTE CAPITAL
 POUR L'EXERCICE TERMINE LE 31 DECEMBRE 1985

SURPLUS AU DEBUT ET A LA FIN DE L'EXERCICE	<u>\$19,488</u>	<u>\$19,488</u>
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LA FONDATION CANADIENNE DE RECHERCHES DENTAIRES

TABLEAU DES INVESTISSEMENTS

AU 31 DECEMBRE 1985

	<u>Coût</u>
Débeture de \$7,000 de la Compagnie Canada Trust à 11.75%, échéant le 18 avril 1987	\$ 7,000
Obligations de \$5,000 de la Commission d'Energie Hydro Electrique de l'Ontario à 9%, échéant le premier avril 1994	<u>5,000</u>
	<u>\$12,000</u>

Clarke
Henning
& Co.

Chartered Accountants

APPENDIX C

44 Victoria Street
Toronto, Ontario
Canada M5C 1Y3
Tel: (416) 364-4421

Partners

D. M. Feldt, C.A.
M. M. Hahn, C.A.
S. Hammond, C.A.
W. J. Henning, B.Com., C.A.
D. G. Hickman, C.A.
E. Hill, C.A.
J. J. Holtom, B.Tech., C.A.
G. Hume, C.A.
R. Hunter, C.A.
C. Jennison, C.A.
R. MacGregor, C.A.
F. McKay, C.A.
M. Post, C.A.
M. Raja, C.A.
J. Reid, C.A.
J. Thompson, B.Com., C.A.
I. I. Zweig, C.A.

February 13, 1986



Mr. A. Jardine Neilson, Executive Director,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario
K1G 3Y6

Dear Mr. Neilson:

CANADIAN DENTISTS' INSURANCE PROGRAM

We are pleased to enclose herewith four bound and one paper-clipped copies of CDIP statement of receipts and disbursements for the year ended December 31, 1985.

If you have any questions in connection with the financial statements, please do not hesitate to contact the writer.

Yours very truly,
CLARKE HENNING & CO.

/jjb

V.M. Raja
V.M. Raja, Partner

Encl.

Member:
International
Affiliation of
Independent
Accounting Firms

CANADIAN DENTISTS' INSURANCE PROGRAM
OF THE CANADIAN DENTAL ASSOCIATION
STATEMENT OF RECEIPTS AND DISBURSEMENTS
Year Ended December 31, 1985

Auditors' Report	Page 1
Statement of Receipts and Disbursements	2
Notes to the Statement of Receipts and Disbursements	3 to 4

Clarke
Henning
& Co.

Chartered Accountants

44 Victoria Street
Toronto, Ontario
Canada M5C 1Y3
Tel: (416) 364-4421



AUDITORS' REPORT

TO THE BOARD OF GOVERNORS OF
CANADIAN DENTAL ASSOCIATION

We have examined the statement of receipts and disbursements for the Canadian Dentists' Insurance Program of the Canadian Dental Association for the year ended December 31, 1985. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, this statement of receipts and disbursements presents fairly all of the receipts and disbursements related to the Canadian Dentists' Insurance Program of the Canadian Dental Association for the year ended December 31, 1985.

Clarke Henning & Co.
CHARTERED ACCOUNTANTS

Toronto, Ontario
January 31, 1986

CANADIAN DENTISTS' INSURANCE PROGRAM
OF THE CANADIAN DENTAL ASSOCIATION

STATEMENT OF RECEIPTS AND DISBURSEMENTS

Year ended December 31, 1985

	1985	1984
Receipts		
Insurance premiums, net of refunds and provincial taxes (note 4)	\$13,204,088	\$12,737,697
Unrecorded premium refunds	<u>(18,435)</u>	<u>(4,919)</u>
	13,185,653	12,732,778
Disbursements		
Net insurance premiums to insurers (note 3)	11,714,584	11,910,686
Collection and administration fees paid to CDSPI (note 5)	1,986,432	1,538,889
Fees to outside administrators	-	61,173
Unallocated disbursements	<u>-</u>	<u>27,437</u>
	13,701,016	13,538,185
Excess of disbursements over receipts	<u>(515,363)</u>	<u>(805,407)</u>
CDIP funds held in trust by CDSPI - beginning of year	3,372,515	4,177,922
CDIP funds held in trust by CDSPI - end of year	<u>\$ 2,857,152</u>	<u>\$ 3,372,515</u>

CANADIAN DENTISTS' INSURANCE PROGRAM
OF THE CANADIAN DENTAL ASSOCIATION

NOTES TO THE STATEMENT OF RECEIPTS AND DISBURSEMENTS

Year ended December 31, 1985

1. Organization

By agreement made between the Canadian Dental Association (CDA) and the Canadian Dental Service Plans Inc. (CDSPI); CDA delegates to CDSPI the functions relating to Canadian Dentists' Insurance Program (CDIP) in which members of the Canadian dental profession and their families and employees may participate.

2. Basis of presentation

The statement of receipts and disbursements presents the receipts and disbursements of CDIP. The statement does not include any income, expenses, assets, liabilities and equity of CDA or CDSPI.

3. Reconciliation of net insurance premiums to gross insurance premiums

	1985	1984
Net insurance premiums paid to insurers per the statement of receipts and disbursements	\$11,714,583	\$11,910,686
Net premiums paid in current year in respect of the previous year	88,273	(868,240)
Net premiums received in current year but not paid until the following year	10,376	4,341
Net premiums multiplied by a factor to arrive at gross premiums	x 1.15	x 1.15
Premiums in respect of current year received in previous year	(1,750,592)	(1,716,700)
Premiums in respect of following year received in current year	1,369,463	1,750,592
Gross premiums per statement of receipts and disbursements	\$13,204,088	\$12,737,697

CANADIAN DENTISTS' INSURANCE PROGRAM
OF THE CANADIAN DENTAL ASSOCIATION

NOTES TO THE STATEMENT OF RECEIPTS AND DISBURSEMENTS

Year ended December 31, 1985

4. Reconciliation of gross insurance premiums received (net of refunds) to gross CDIP premiums per CDSPI annual financial statements for the year ended December 31 on an accrual basis:

	1985	1984
Gross premiums received per the statement of receipts and disbursements	\$13,204,088	\$12,737,697
Premiums in respect of the current year received in previous year	1,750,592	1,716,700
Premiums in respect of the following year received in current year	(1,369,463)	(1,750,592)
Premiums in respect of the following year received and not paid in current year	(11,932)	(4,993)
Gross CDIP premiums per CDSPI financial statements	<u>\$13,573,285</u>	<u>\$12,698,812</u>

5. Collection and administration fees paid to CDSPI

	1985	1984
Accounts payable - beginning of year	\$ 215,894	\$ -
Collection and administration fees	1,770,538	1,754,783
Accounts payable - end of year	-	(215,894)
Fees paid to CDSPI per statement of receipts and disbursements	<u>\$ 1,986,432</u>	<u>\$ 1,538,889</u>

6. Comparative figures

The comparative figures for 1984 were reported upon by another firm of auditors.

CDA Position On

A CERTIFYING BOARD FOR GENERAL DENTISTRY

The Canadian Dental Association opposes the establishment of a Certifying Board for General Dentistry for the following reasons:

National certification of dental practitioners is currently the responsibility of the N.D.E.B. of Canada, a body established under Federal legislation. The NDEB certificate is recognized, for purposes of licensure, in all provinces. The evolution of this national certifying process - a development not paralleled in the United States - represents an accomplishment worth preserving. The need for a separate and distinct certificate from a Certifying Board For General Dentistry is not apparent and could compromise this achievement.

In addition, Undergraduate Dental Education in Canada is in the fortunate position of having current graduates of CDA accredited educational programs recognized for NDEB certification without further examination. Such a process of recognition grants the fullest degree of autonomy and respect to accredited educational programs. A new and separate certifying examination would be a retrograde step.

Preparation of the general dental practitioner remains the primary goal of the undergraduate dental education programs whose graduates are certified by the NDEB in this fashion.

There are a number of groups currently involved with continuing education for general dental practitioners, including CDA, NDEB and provincial licensing authorities working in co-operation with Canadian Faculties of Dentistry. At the request of the NDEB, CDA is currently exploring means of developing continuing education programs linked to the specific needs of individual general dental practitioners concerned with maintenance of professional competence.

The introduction of a certifying board for general dentistry would establish two levels of general practitioners and unnecessarily create disunity in a profession founded on the principle that all dentists must be general practice dentists, regardless of additional specialization in specific fields of interest. Completion of an approved undergraduate educational program in dentistry should continue to be the fundamental prerequisite for recognition as a general dental practitioner. The National Dental Examining Board Certificate should continue to provide the basis for national portability. An additional certificate is not required to attest to the skills, value or worth of the basic Canadian dental practitioner nor to achieve national portability of general dental practitioners.

BJH:dh

Nov.29, 1985

The College of Dental Surgeons of Saskatchewan

109 - 514 - 23rd STREET EAST
SASKATOON, SASK.
S7K 0J8

G. H. PEACOCK, D.D.S.
SECRETARY-REGISTRAR-TREASURER
(306) - 244-5072

January 23, 1986.

Mr. A. Jardine Neilson,
Executive Director,
Canadian Dental Association,
1815 Alta Vista Drive,
OTTAWA, Ontario.
K1G 3Y6.

86.01.27

Dear Mr. Neilson:

This correspondence is being forwarded to your attention in response to your letter of December 3, 1985 in which you requested my comments on points respecting the Canadian Dental Association Management Committee and the Canadian Dental Association Executive Council.

Following receipt of your letter, your request was copied to the members of the Council on Constitution and By-laws and was discussed during a conference call which took place on January 16, 1986.

The Council on Constitution and By-laws after due consideration of the items you raised, offers the following response.

1. Management Committee

The enabling legislation for the establishment of the Management Committee is contained within Article XI, Section 6. This section states that the Management Committee is

- a) a committee of the Executive Council and
- b) shall consist of three members, the President, the Immediate Past-President and the President Elect.

2. Article IX, Section 1 provides the enabling legislation for the Executive Council and Article IX, Section 2 indicates its composition, in which the President, Immediate Past-President and President Elect are among those so listed.

3. Article IX, Section 3 refers to the qualifications necessary to be a member of the Executive Council, that being the member must be a member of the Board of Governors.

... 2

4. Article VIII, Section 1 substantiates this fact, in that a member of the Management Committee must be a member of the Board of Governors, as the Management Committee is composed of the President, Immediate Past-President and the President Elect.
5. On the basis of this fact, your Council referred to Article VIII, Section 4 which outlines four methods in which the office of a member of the Board of Governors may be vacated, these being
 - (a) if his name is removed from the register of dentists, licensed to practise in a province in Canada.
 - (b) upon receipt of notification from the Corporate member or the Council on Student Affairs he represents.
 - (c) if he is convicted of a criminal offence.
 - (d) if by notice in writing to the Executive Director of the Association he resigns his office.

Based on the above points, it therefore appears that a Member of the Management Committee, on the basis that he is a member of the Board of Governors, could vacate or be vacated from his position through applicable provisions of Article VIII. The questions as to whether a member of the Management Committee could be removed by the Corporate body who originally named them to the Board is not specifically answered in the current constitution and by-laws; however there appears to be intent written therein which suggests that they could not be removed.

Article VIII, Section 1 (a) indicates that the Board of Governors shall include (1) the President (2) the Immediate Past-President and (3) the President Elect. The next part of this subsection then outlines the corporate member, composition of the Board of Governors and how many from each corporate member, as based on the number of active and licensed dentists and other representatives. This would suggest that the President, the Immediate Past-President and the President Elect are viewed distinct from the corporate appointees.

To compliment this, Article VIII, Section 2 (c) provides a mechanism wherein a corporate member may elect or appoint another representative to fill the vacancy created if a representative of the corporate member assumes the office of President Elect.

The above two provisions may be perceived as an indication that the members of the Management Committee are not appointed or elected representatives of corporate members, and thus not subject to the provisions of Article VIII, Section 4 (c).

Your Council is of the opinion that if Executive Council wishes to include a mechanism protecting the security of the Management Committee, and or is concerned about a mechanism of possible impeachment of a member of the Management

... 3

Committee, that an amendment to the Constitution and By-laws be considered wherein it would state that "a member of the Management Committee could only be removed from office by a majority decision of the Board of Governors, on the recommendation of Executive Council".

It is further suggested that this could be accomplished by rewriting Article VIII, Section 4, or by amending Article XI, Section 6, by adding "Subject to Article VIII, Section 4, (a) (c) and (d) a member of the Management Committee could only be removed from office by a majority decision of the Board of Governors, on recommendation of Executive Council.

Executive Council

In the viewpoint of your Council, the situation involving Executive Council is somewhat different. In the case of the Management Committee the primary responsibility is to the Canadian Dental Association. In the case of a member of the Executive Council, the member has a responsibility to the Canadian Dental Association, but also one to the Corporate Body who appointed or elected him to the Board of Governors. By building in a mechanism wherein such a member could not be removed from Executive Council by the Corporate Member who appointed or elected him, could be conceived to be an infringement on the Provincial Act, Regulations, By-laws or Guidelines which gave the statutory power to the Corporate Body to appoint or elect that individual in the first place. As well, such a mechanism could prove to be a complicating factor in situations where an Executive Council member could represent not only his own Corporate body, but also that of one or more Corporate bodies at the Executive Council level.

One mechanism through which an Executive Council member could be protected would be similar to Management Committee wherein assuming a position on Executive Council, the Corporate member could appoint another representative to the Board of Governors; however our Council is in no way recommending this be undertaken considering all factors including the resultant increase in the size of the Board of Governors and associated costs.

Although some members of your Council were of the opinion that Executive Council members should be protected from removal from Executive Council, it was felt that an agreement on this would be difficult to achieve given the Corporate representation on the Board and the various methods of their appointment or election to the Board.

In conclusion, Council directed that the opinions in this letter be provided to the Board at the interim meeting through our Council. After further deliberation by myself and further communication with our Executive Liaison, I decided to reply directly to Executive Council. It was my interpretation of your letter of December 3, 1985 that by replying directly to Executive Council, that body could deliberate further on the matter, prior to it being subject to discussion at a Board meeting.

... 4

- 4 -

Your Council awaits further direction from the Executive Council either through correspondence, or by direction initiated by the Executive Council to a meeting of the Board of Governors.

Yours sincerely,



G.H. Peacock, D.D.S.,
Chairman,
Canadian Dental Association,
Council on Constitution and
By-laws.

GHP/mf
c.c. Dr. E.F. Allison -
Executive Liaison.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

December 3, 1985

Dr. George Peacock
College of Dental Surgeons of Sask.
109 - 514 - 23rd Street E.
SASKATOON
(Saskatchewan)
S7K 0J8

Dear George:

Recent actions of the QDSA in removing their Governors from the CDA Board of Governors, has prompted our Executive to seek an examination of the Constitution and By-Laws, as they deal with appointments to the Executive Council and elections to the Management Committee.

In your capacity as chairman of the Council on Constitution and By-Laws, the Executive Council, therefore, requests that you comment on several points.

CDA Management Committee

As you know, the Management Committee of the CDA is comprised of the President-Elect, President and Past-President. Under the present terms of the Constitution & By-Laws, is there a mechanism whereby any one of these officials may be removed from office? For example, as they are members of the Board of Governors, could the corporate body who originally named them to the Board, effect their removal from office by indication of non-support? Would a majority vote of the Board of Governors be required to remove all or any one of them from office?

The above queries do not appear to be answered in the present documentation (Constitution & By-Laws). The Executive Council feels that, at least, the President, President-Elect, and Past-President should not be subject to instruction or control by any corporate body, and requests your recommendation as to what revision to the Constitution & By-Laws would be necessary to guarantee this immunity.

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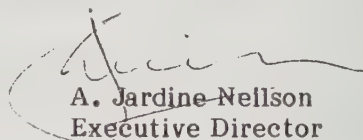
CDA Executive Council

Under the present terms of the Constitution & By-Laws, members of Executive Council can be removed from their positions on Council, by their Corporate Bodies' withdrawing their mandates as Governors to the Board. The Executive Council questions the advisability of allowing this procedure to stand, due to the adverse effect such actions can have on the operation of the Executive Council in carrying out its responsibilities to the Canadian Dental Association.

Again, your comment is requested on the advisability of an amendment to the Constitution & By-Laws, which would make members of Executive Council immune to removal from the Board of Governors and thus, Executive Council.

The foregoing is considered to be extremely important by Executive Council members. The issues are recognized to be complex; may I wish you success in your deliberations.

Sincerely yours,


A. Jardine-Nellson
Executive Director

c.c. Dr. Bradley W. Holmes, President
Dr. T. Allison, Executive Liaison - Constitution & By-Laws

CURRENT

Section 8 - Duties of Executive Council

It shall be the duty of the Executive Council

- (a) to supervise the maintenance of headquarters property owned or operated by the Association.
- (b) to appoint the Executive Director of the Association.
- (c) to determine the date and place for convening each annual meeting of the Association.
- (d) to approve all clinics and exhibits in line with policies established by the Board of Governors.
- (e) to cause to be bonded by a surety company all appointed officers and employees of the Association entrusted with Association funds.
- (f) to ensure all accounts of the Association are audited by a certified chartered accountant at least once a year.
- (g) to prepare a budget for carrying on the activities of the Association for each ensuing fiscal year.
- (h) to review reports prepared for presentation and make recommendations concerning each report to the Board of Governors.
- (i) to submit an annual report of the Executive Council activities to the Board of Governors and following each Executive Council meeting to submit a summary statement of the business of the meeting to the members of the Board of Governors.
- (j) to annually recommend to the President chairmen of the councils excluding Executive, Student Affairs and Nominations from among membership of the respective councils as elected by the Board of Governors.
- (k) to perform such other duties as are prescribed in these By-laws.
- (l) to admit Associate, Affiliate and Supporting members pursuant to Article V, Section 3, 6 and 8, and to elect Honorary members pursuant to Article V, Section 4.
- (m) to grant awards from time to time in accordance with the guidelines established by the Board of Governors.

Section 9 - Sessions

- (a) Regular Session

The Executive Council shall hold at least four regular sessions in each year.

EXECUTIVE COUNCIL

PROPOSED

Roles and Responsibilities

- (a) shall act on behalf of the Board of Governors establishing interim policies when the Board is not in session and where such action in the discretion of Executive Council is essential to the management of the Association, provided that such action must be reported to the Board within fourteen (14) days and presented by Executive Council for review at the next following session of the Board of Governors.
- (b) shall establish guidelines and policy related to the administration of the Association in consultation with the Executive Director.
- (c) shall have full discretionary powers to cause to be published in or omitted from any official publication of the Association, any article in whole or in part, except the editorials written or approved by the editors.
- (d) shall be the trustees of all funds, properties and other assets of the Association.
- (e) shall report to each meeting of the Board of Governors.
- (f) shall provide the recommended agenda for each Board of Governors meeting and shall review all reports prepared for presentation and make recommendations concerning each report.
- (g) shall perform such duties as may be designated by the Board of Governors or this by-law.
- (h) shall ensure that a Management Planning Process and Priorities are established and carried out for the Association.
- (i) shall provide Executive Liaison to all Councils and Committees as deemed necessary.
- (j) shall appoint the Executive Director of the Association.
- (k) shall determine the date and place for convening each annual and interim meeting of the Association.
- (l) shall approve all clinics and exhibits in line with policies established by the Board of Governors.
- (m) shall cause to be bonded by a surety company all appointed officers and employees of the Association entrusted with Association funds.

CURRENT

Section 7 – Powers

The Executive Council shall conduct all business of the Association when the Board of Governors is not in session, subject to the Letters Patent, By-laws of the Association and the mandates of the Board of Governors.

- (a) The Executive Council shall have power to establish administration rules and regulations not inconsistent with these by-laws.
- (b) The Executive Council shall have power to direct the President to call a special session of the Board of Governors pursuant to Article VIII, Section 7.
- (c) The Executive Council shall have full discretionary powers to cause to be published in or omitted from any official publication of the Association, any article in whole or in part, except the editorials written or approved by the Editors.
- (d) The Executive Council shall have power to establish interim policies when the Board of Governors is not in session and where such policies in the discretion of the Executive Council are essential to the management of the Association, provided however that such policies must be reported to the members of the Board of Governors within fourteen (14) days of establishment thereof and presented by the Executive Council for review at the next following session of the Board of Governors.
- (e) The Executive Council shall have the right to elect Honorary members.
- (f) The time and manner of distribution of surplus funds to the members participating in insurance plans shall be determined by the Executive Council.
- (g) The Executive Council will authorize and approve all contracts, agreements or the disposition of funds relating to insurance and investment programmes.
- (h) The Executive Council will act as trustees for all insurance retention funds or surplus or reserve funds.

Executive Council - Proposed

- (n) shall ensure all accounts of the Association are audited by a certified chartered accountant at least once a year.
- (o) shall review the draft budget for carrying on the activities of the Association for each ensuing fiscal year and make recommendations on the budget to the Board of Governors.
- (p) shall submit a report of the Executive Council activities to each meeting of the Board of Governors and following each Executive Council meeting to submit a summary statement of the business of the meeting to the members of the Board of Governors.
- (q) shall annually recommend to the President, chairpersons of the councils except as exempt by the Constitution and By-Laws, from among membership of the respective council.
- (r) shall admit Associate, Affiliate and Supporting members pursuant to Article V, Section 3, 6 and 8 and to elect Honorary members pursuant to article V, Section 4, and Life Members according to Article V, Section 5.
- (s) shall grant awards from time to time in accordance with the guidelines established by the Board of Governors.
- (t) shall act as trustees for all insurance, retention funds, surplus and reserve funds and shall determine the time and manner of distribution to the members participating in insurance plans.
- (u) shall authorize and approve all contracts, agreements or the disposition of funds relating to insurance and investment programs.
- (v) shall have power to direct the President to call a special session of the Executive Council.
- (w) shall hold at least four regular sessions in each year.

CURRENT

Section 6 - Management Committee

The Management Committee shall be a committee of the Executive Council and shall consist of three members, the President, the Immediate Past-President and the President-Elect who shall be the chairman:

- (a) to serve as custodian of all monies, securities and deeds belonging to the Association.
- (b) to present an annual report to the Board of Governors including the Auditors' Report for the preceding year and the budget that has been proposed for the next succeeding fiscal year.
- (c) to perform such other duties as may be designated by the Executive Council or these By-laws.
- (d) to keep a minute book.

MANAGEMENT COMMITTEE

PROPOSED

Roles and Responsibilities

The Management Committee shall be a committee of the Executive Council and consist of three members, the Immediate Past-President, the President-Elect and the President who shall be the chairperson:

- (a) shall assure that all money securities, deeds and real property belonging to the Association are properly secured and accounted for.
- (b) shall provide advice to Executive Council on the Association's affairs.
- (c) shall perform such other duties as may be designated by the Executive Council or these By-Laws.
- (d) shall keep a Minute Book and report to the Executive Council.
- (e) shall review all budgets and financial statements presented by the President-Elect for the forthcoming year and the auditor's reports prior to presentation to the Executive Council and Board of Governors.

CURRENT

Section 15 - Duties of the Chairman of the Board

- (a) to preside at meetings of the Board of Governors and perform such duties as custom and parliamentary usage require.
- (b) to appoint a secretary pro tem in the absence of the Secretary of the Board.
- (c) to appoint, with the consent of the Board of Governors, special committees to perform duties not otherwise assigned by By-laws, which special committees shall serve until adjournment of the session at which they were appointed.
- (d) to appoint scrutineers to assist in determining the result taken by vote of the Board of Governors.

The Chairman of the Board shall hold no other elective office in the Association while he is serving as Chairman of the Board.

CHAIRMAN OF THE BOARD OF GOVERNORS

PROPOSED

Roles and Responsibilities

- (a) shall preside at meetings of the Board of Governors and perform such duties as custom and parliamentary usage require.
- (b) shall appoint a secretary pro tem in the absence of the Secretary to the Board, in consultation with Management Committee.
- (c) shall appoint scrutineers to assist in determining the result taken by vote of the Board of Governors.

The Chairman of the Board shall hold no other elective office in the Association while he is serving as Chairman of the Board.

CURRENT

Section 5 - Duties of the Executive Director

The duties of the Executive Director shall be:

- (a) to act as executive head of the Association.
- (b) to engage all employees of the Association except as otherwise provided in these By-laws.
- (c) to co-ordinate the activities of the Executive Council and all councils of the Association.
- (d) to offer advice on all policy matters to the Board of Governors, other Councils and Committees of the Association.
- (e) to direct that the policies of the Board of Governors be implemented.
- (f) to draw on the resources of the Association in preparing assistance to the Board of Governors, other Councils and Committees of the Association.
- (g) to keep the records, minutes and be custodian of books, papers, documents and seal of the Association.
- (h) to pay all accounts and keep accurate record of receipts and disbursements.
- (i) to furnish a surety bond in amount determined by the Executive Council, the premium of which shall be paid by the Association.
- (j) to perform such other duties as usually appertain to this office or as may be designated by the Executive Council or these By-laws.

EXECUTIVE DIRECTOR

PROPOSED

Roles and Responsibilities

- (a) shall be the Chief Executive Officer of the Association.
- (b) shall employ all staff of the Association, subject to budgetary, staffing and compensation policies established by the Board of Governors.
- (c) shall implement decisions made by the Executive Council and/or Board of Governors.
- (d) shall coordinate all activities of the Board of Governors, Councils and Committees of the Association.
- (e) shall offer advice on policy matters to the Board of Governors, other Councils and Committees of the Association.
- (f) shall draw on the resources of the Association in preparing assistance to the Board of Governors, other Councils and Committees of the Association.
- (g) shall keep the records and minutes and be custodian of books, papers, documents and seal of the Association.
- (h) Shall be custodian of all monies, securities, deeds and real property belonging to the Association.
- (i) shall cause to be paid all accounts and keep accurate records of receipts and disbursements.
- (j) shall furnish a personal surety bond in amount determined by the Executive Council, the premium of which shall be paid by the Association.
- (k) shall perform such other duties as usually appertain to this office or as may be designated by the Executive Council or these By-Laws.
- (l) shall supervise the maintenance of headquarters property owned or operated by the Association.
- (m) shall act as secretary to the Board of Governors.

CURRENT

Section 2 - Duties of the President

It shall be the duty of the President:

- (a) to preside at all meetings of the Executive Council in accordance with recognized parliamentary usage.
- (b) to serve as an official representative of the Association in its contacts with government, civic, business and professional organizations for the purpose of advancing the objects and policies of the Association.
- (c) to serve as an ex-officio member of all councils of the Association.
- (d) to make a report at the annual meeting of the Board of Governors.
- (e) to make interim appointments in case of vacancies occurring in the Executive Council or in other councils.
- (f) to appoint special committees when considered necessary.
- (g) to call special sessions of the Executive Council.
- (h) to sign all official documents requiring his signature.
- (i) to delegate his responsibilities for appropriate reason when he is unable to fulfill same.
- (j) to perform such other duties as may be provided in these By-laws subject to Article IX, Section 6 and Section 8.
- (k) to succeed to the office of the Past-President.

PRESIDENT

PROPOSED

Roles and Responsibilities

- (a) shall be the Chief Elected Officer of the Association.
- (b) shall have the authority to act on behalf of the Executive Council and/or Board of Governors when necessary, in consultation with, and with the concurrence of, the majority of the membership of the Management Committee.
- (c) shall be the chief spokesperson of the Association.
- (d) shall be the Chairperson of the Executive Council and the Management Committee.
- (e) shall serve as ex-officio member of all councils and committees of the Association.
- (f) shall report to all meetings of the Board of Governors and Executive Council.
- (g) shall make interim appointments to fill vacancies existing in all Councils and Committees.
- (h) shall be responsible for appointing special committees when necessary, in consultation with, and with the concurrence of, the majority of the membership of the Management Committee.
- (i) shall be responsible for calling sessions of the Executive Council and the Board of Governors.
- (j) shall sign official documents when required.
- (k) shall delegate his responsibilities for appropriate action when he is unable to fulfill some.
- (l) shall perform such other duties as may be provided in these By-Laws subject to Article IX, Section 6 and Section 8.
- (m) shall succeed to the office of the Past-President.

CURRENT

Section 3 - Duties of the President-Elect

It shall be the duty of the President-Elect:

- (a) to assist the President as requested in the performance of his duties.
- (b) to serve as Acting President in the event that the office of the President becomes vacant.
- (c) to act as Chairman of the Management Committee.
- (d) to succeed to the office of the President at the next annual meeting of the Board of Governors following his election as President-Elect.

PRESIDENT-ELECT

Roles and Responsibilities

PROPOSED

- (a) shall assist the President as requested in the performance of his duties.
- (b) shall serve as Acting President in the event that the office of the President becomes vacant.
- (c) shall be responsible to oversee the preparation and presents the budget to the Executive Council and the Board of Governors.
- (d) shall present the financial statement to the Executive Council and the Board of Governors.
- (e) shall succeed to the office of the President at the next annual meeting of Board of Governors following election as President-Elect.

PAST-PRESIDENT

Roles and Responsibilities

CURRENT

- a) To assist the President as requested, in the performance of his duties.
- b) to act as Chairman of the Nominations Council.
- c) to be a member of the Management Committee.
- d) to act as Chairman of the Membership Committee (effective immediately after the annual Board of Governors' meeting).

PAST-PRESIDENT

Roles and Responsibilities

PROPOSED

- a) shall assist the President as requested, in the performance of his duties.
- b) shall act as Chairperson of the Council on Nominations, Awards and Trusts.
- c) shall be a member of the Management Committee.
- d) shall act as Chairperson of the Membership Committee (effective immediately after the annual Board of Governors' meeting).

EDITORIAL BOARD

REPORT TO THE INTERIM CDA BOARD OF GOVERNORS MEETING
APRIL 1986

Members: Dr. John Hardie, Chairman, Ontario
 Dr. J.D.R. Grier, British Columbia
 Dr. M. Klotz, Ontario
 Dr. A.D. Sparrow, Alberta
 Dr. R.S. Turnbull, Ontario
 Dr. P.C. Desautels, Québec

1. Board Meeting

The Board met on November 22, 1985. In addition to the Board members the following were present:

Ms. C. Hackland, Journal Editor, C.D.A.
Mr. C. Metcalfe, Journal Associate Editor, C.D.A.
Ms. A. Spencer, Journal Advertising Manager, C.D.A.
Ms. C. Elliott, Journal Production Assistant, C.D.A.

Items for Information - Requiring Board Action

2. Financial Report

Advertising is the main source of income, and an increase in the advertising base is a major method of increasing revenues. The advertising manager stated that:

- i The decrease in advertising dollars has reached its lowest point now that the reduced circulation figures have been appreciated, for some time, by the advertisers.
- ii That the advertising revenues should slowly start to increase with stabilization of the circulation figures.

The advertising manager was asked to prepare a report on how the advertising revenue could be increased, if this would impact upon the present standards for advertisements, and if commissioned salesmen would be advantageous.

The Board was concerned that C.D.S.P.I. had advertised in Oral Health. If this has fractured a traditional exclusive relationship, then the Journal may consider advertisements from similar commercial enterprises. Therefore the Editorial Board recommends,

THAT whereas there is a special advertising agreement between C.D.S.P.I. and the Journal, involving restrictions of advertising by competing companies, and whereas C.D.S.P.I. has recently advertised in Oral Health, the Editorial Board moves that the relationship between C.D.S.P.I. and the Journal be reviewed.

Executive Council agrees that the matter of advertising by CDSPI in other dental journals warrants review and further has directed that the Management Committee review this item with the Chairman of the Editorial Board before providing direction to CDSPI.

RESOLVED:

86.14 THAT the existing relationship between CDSPI and the CDA Journal with respect to advertising remain unchanged.

ADOPTED

The editor was asked to review printing and publishing costs, and to determine if more economical contracts could be obtained.

Items for Information - Not Requiring Board Action

3. Interviews with Editors

- i In mid-October 1985, Ms. Carolyn Hackland and Dr. John Hardie held meetings with the Editors of the Journals of the Canadian Medical Association (CMA), Canadian Pharmaceutical Association (CPhA), and the American Dental Association (ADA). Mr. D. Woods (CMA) is a journalist with many literary credits, and experience with medical journals. Mr. J-G Cyr (CPhA) and Dr. R. Scholle (ADA) are respectively a pharmacist and oral pathologist, both with limited editorial and publishing experience prior to assuming their present appointments.

-
- ii Each editor complimented the JCDA for its appearance and content, and welcomed the opportunity to discuss their specific roles, mandates, successes, and failures.
- iii The editors were committed to the philosophy that a national professional organization should produce a journal for the dissemination of pertinent knowledge and information. While the journal should attempt to be fiscally viable, this should not detract from the need to create effective communication within the appropriate profession.
- iv It was uniformly accepted that the spectrum of interest dictates that articles in a national professional journal will not appeal to every reader, unlike commercial enterprises which target specific topics or professionals. The editors had accepted this challenge by: increasing rather than decreasing the range of subjects, soliciting timely and controversial articles, utilizing current printing techniques, seeking new sources of advertising revenue, and adopting appropriate fiscal controls.
- v Each editor operated without a formal editorial board, and with more support staff than is available at the JCDA. The relative autonomy enjoyed by the editors facilitated the implementations of rational changes. They accepted the responsibility for success and failure, and were re-appointed at the discretion of the respective Board of Trustees.
- vi In summary, the editors were committed to providing a journal which represented the scientific, social, political, and fiscal concerns of the profession and its members. They were prepared to be informed, innovative, and forceful to ensure the fulfillment of this mandate.

4. Editorial Board Comment on Interviews

On consideration of the above report the voting members of the Editorial Board, at the meeting on November 22nd, 1985, appreciated that:

- i The Canadian Dental Association has an obligation to publish a National Journal.
- ii The Editor plays a pivotal role in the success of the Journal.
- iii The Editorial Board has a limited, if any, disciplinary responsibility towards the Editorial Staff.
- iv The Editorial Board should act as an advisory body; offering information on trends, controversial topics, future articles, suitable contributors, and providing constructive criticism.
- v The Editor should be responsible for the content presentation, and fiscal viability of the Journal.
- vi The terms of reference of the Editor and Editorial Staff should reflect their responsibilities and reporting mechanisms.
- vii Terms of reference for members of the Editorial Board need to be described.
- viii The President, Executive Director, and Chairman of the Editorial Board should meet to discuss the mechanisms of realizing items iv - vii.

5. Scientific Articles

The lead time for publication of such articles is one year. The editor was asked to assess the cost of publishing four articles per issue to reduce this hiatus.

6. Innovations

- i The first clinical article, based upon a table clinic, was published in October 1985. The second was published in February 1986. Although the articles often require extensive rewriting they are considered to be valuable material for the new Clinical Features section.

-
- ii The final freelance contract has not been reviewed by the Board but it was decided to commission Mr. David Woods to write six health related columns for monthly publication. These will be assessed at the next Board meeting.
 - iii The Board members were pleased with the format of the new reprints, and considered any increase in costs to be justified.
 - iv In future, reviewers of text-books will receive a certificate of appreciation for their efforts.
 - v A Dental Awareness Program Update page prepared by Manifest Communications, began in the January 1986 issue. This page will appear in every issue with DAP News for the readership.

6. Summary

The Editorial Board has offered a number of suggestions to continue the obvious improvements and increasing relevance of the Journal. The interviews with the experienced and respected editors demonstrated the central role played by the editor of a professional journal. Therefore, the editor should be given the necessary support and mandate to guide the Journal with occasional navigational instructions from the Editorial Board.

Respectfully submitted

J. Hardie, B.D.S., F.R.C.D.(C)
Chairman
Editorial Board

ADOPTION OF REPORT

The Board of Governors receives the report of the Editorial Board with appreciation.

MEMBERSHIP COMMITTEE

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. Ralph Crawford, Chairman, Winnipeg, Manitoba
Dr. Bradley Holmes, CDA President, Kenora, Ontario
Dr. Ed Busvek, St. Thomas, Ontario
Dr. Rita Hurley, Montreal, Quebec
Dr. Lynn Tomkins, Scarborough, Ontario
Brig.-General J.N. Wright, Ottawa, Ontario

CDA Staff Resource: Jean Scrimger, Director of
Administration

1. Council Meetings

Meeting held December 7, 1985; CDA Headquarters, Ottawa.

2. Items Requiring Board ActionChanges to Membership Categories:

At the Annual Board of Governors meeting Notices of Motion were directed to the Council on Constitution and By-Laws concerning Life Membership and Supporting Membership. The Notices were discussed and the following amendments were proposed.

(a) Life Membership:

The Committee felt the definition too restrictive as many dentists do not practice for 40 years, particularly in the case of specialists. It was proposed to delete Active or Affiliate member status and would include all membership categories. Thus all member years from Student to membership under the Associate/Supporting category due to retirement would count toward the honour.

MEMBERSHIP COMMITTEE

2. Items Requiring Board Action

(a) Life Membership - cont'd

THAT the Life Membership category be revised with the direction that in order to obtain a CDA Life Membership a dentist shall have been a member of the CDA in good standing for a minimum of 40 years regardless of age of applicant

The above motion was received as information by the Board and considered during the report of the Council on Constitution & By-Laws.

(to confirm eligibility for Life Membership and ascertain "good standing" each corporate member in the mandatory provinces will be requested to verify membership year history and ratify the Life Membership status. In Ontario and Quebec the history will need to be verified by each member).

(b) Supporting Membership:

THAT the Supporting Member category read as follows:

THAT any dentist in good standing who is no longer licensed to practise in a province of Canada, or who is fully retired from dental practice, teaching or administration or who presents special mitigating circumstances, shall be eligible to apply for admission as a Supporting member and shall become a Supporting member upon approval by the Executive Council and payment of the appropriate fee.

The above motion was received as information by the Board and considered during the report of the Council on Constitution & By-Laws.

(c) Student Membership:

The present category of Student membership restricts membership to those only studying in Canada and excludes Canadian citizens who may be studying abroad, and who may wish to retain CDA affiliation. A motion is proposed that will change Article V, Section 7.

MEMBERSHIP COMMITTEE

2. Items Requiring Board Action

(c) Student Membership: - cont'd

86.15 RESOLVED:

THAT the Student Member category read as follows:

Any undergraduate student in an accredited dental school in Canada, or any Canadian citizen who is a student in a CDA recognized Faculty of Dentistry outside Canada, who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

ADOPTED

DIRECTION: The Motion 86.15 will be referred to Council on Constitution and By-Laws for necessary action.

3. Items for Information - Not Requiring Board Action

i Associate Member:

APPENDIX I

The applications for Associate Member status are appended.

ii 1986 Campaign:

APPENDIX II

Committee reviewed the 1986 membership campaign. Indications were that membership figures for Ontario were slightly ahead of 1985 and Quebec's were considerably ahead by about 200. Staff had prepared special mail out letters to the different categories in the voluntary provinces, i.e. renewing members, new graduates, associate/supporting members.

MEMBERSHIP COMMITTEE

3. Items for Information - Not Requiring Board Action

- iii The December CDA Journal was sent to all dentists in Canada and the issue contained a two-page spread regarding Membership News.

Non-members of CDA will also be receiving the March Journal. Health and Welfare Canada are paying for extra issues to non-members in order that their Report on the Working Group on Dental Hygiene be sent to all dentists. This March Journal issue will again carry Membership information in a two-page spread format.

- iv CDA Communication Coordinators:

The luncheon for voluntary coordinators scheduled for November 9, 1985 was cancelled due to limited response....(difficult to get all volunteers together in Ottawa at one time!) Another workshop is proposed for the 1987 budget year. The present coordinators are being requested to contact non-members in their area re: joining CDA, and add their personal encouragement in the second invoice.

- v Professional Marketing Service:

The utilization of Professional Marketing Service for the 1986 campaign was discussed but considered not cost effective. Staff will investigate further this strategy for 1987.

- vi Stratford Dental Society:

Drs. Crawford and Holmes reported on their visit to Stratford, Ontario where only 20% of the dentists belonged to CDA. It was an informative evening of answering numerous questions which proved interesting (and hopefully brought new CDA members!).

- vii Call the President Day:

CDA President Dr. Holmes reported that such a membership service will be held on April 2, 1986.

- viii CDA Annual Directory:

The reprinting of the directory was discussed - (the latest directory was in 1982). Production costs are high; requests are minimal and it would appear that commercial entities seemed to benefit the most.

MEMBERSHIP COMMITTEE

3. Items for Information - Not Requiring Board Action

The jeopardy of member's privacy was also discussed. The decision was made not to produce a CDA directory at this time.

ix Display Booth:

Committee was advised that CDSPI had a second-hand display booth, in good condition, for sale for \$500. Committee decided that the booth could effectively be used for promotion services, and agreed to the purchase. The \$500 purchase cost be from the 1986 Committee budget and the necessary refurbishing costs be considered in the 1987 budget.

x CDA Journal: "Did You Know"

A request would be made to the CDA Journal that it print a regular monthly column "Did You Know", produced by the Membership Committee and carry regular membership benefits.

xi Students' Council Liaison

The Committee decided that liaison between itself and the Students Council should be ongoing and that representation would be scheduled on an annual basis to the Ottawa meeting of Students' Council.

Respectfully submitted,

Ralph Crawford,
Membership Chairman

ADOPTION OF REPORT

The Board of Governors receives the report of the Membership Committee with appreciation.

APPENDIX I

APPLICANTS FOR ASSOCIATE MEMBER STATUS
APPROVED BY MEMBERSHIP COMMITTEE

NAME	PROVINCE	REASON
Dr. Lyle Oliver	Ontario	Expenses/Recent Grad
Dr. Sidney Moll	Ontario	Illness
Dr. D.H. Protheroe	Ontario	Retired/non licensed
Dr. R.G. Balderson	Ontario	Retired/non licensed
Dr. R.T. Boyd	Ontario	Not licensed
Dr. J.A. Alexander	Ontario	Not licensed
Dr. Donald Chaloner	Quebec	Retired/licensed

CANADIAN DENTAL ASSOCIATION

1986 MEMBERSHIP RETURNS AS AT March 7th, 1986

	<u>ONTARIO</u>	<u>QUEBEC</u>	<u>TOTALS</u>
<u>1986</u>			
AT <u>82</u> DAYS			
ACTIVE & AFFILIATE	2,442	1,312	3,754
ASSOCIATE	9	5	14
POST GRAD/STUDENT FEES	59	34	93
<u>TOTAL PAID FEES:</u>	<u>2,510</u>	<u>1,351</u>	<u>3,861</u>
LIFE - PAST PRESIDENTS			
HONORARY	384	143	527
<u>TOTAL</u>	<u>2,894</u>	<u>1,494</u>	<u>4,388</u>

1985

AT <u>82</u> DAYS			
ACTIVE & AFFILIATE	2,418	1,068	3,486
ASSOCIATE	37	21	58
POST GRAD/STUDENT FEES	61	51	112
<u>TOTAL PAID FEES</u>	<u>2,516</u>	<u>1,140</u>	<u>3,656</u>
LIFE - PAST PRESIDENTS			
HONORARY	332	116	448
<u>TOTAL</u>	<u>2,848</u>	<u>1,256</u>	<u>4,104</u>

<u>TOTAL PAID FEES</u>	<u>1985</u>	<u>2,696</u>	<u>1,297</u>
	<u>1984</u>	<u>2,821</u>	<u>1,257</u>
	<u>1983</u>	<u>2,697</u>	<u>1,267</u>
	<u>1982</u>	<u>2,495</u>	<u>1,277</u>

cc: Dr Bradley W Holmes
 Membership Committee
 Anna Spencer, Adv. Mgr.

THIRD PARTY DENTAL PLANS COMMITTEE

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. D. E. MacFarlane, Chairman, Vancouver
 Dr. D. Gutkin, Winnipeg
 Dr. T. Gushue, St. John's
 Dr. W. Leggett, Brampton

 Dr. R.J. Markey, Executive Liaison, Vancouver

1. Committee Meetings

The Committee has met twice since the last report to the CDA Board of Governors, December 9, 1985 and January 26 & 27, 1986. The Sub-Committee on Alternate Delivery Systems met with Committee on January 26th.

ITEMS REQUIRING BOARD ACTION

2. CDA Standard Claim Form

Attached as Appendix I is the Canadian Dental Association standard dental claim form which has been agreed upon between the dental prepayment industry and the Third Party Committee. We believe this form to be a significant improvement warranting acceptance.

APPENDIX 1

RESOLVED:

86.16 THAT the revised CDA Standard Dental Claim Form be approved.

ADOPTED

3. Revised Budget for Third Party Committee 1986

Attached as Appendix II is a report presented to the Third Party Committee by Dr. MacFarlane in which the Chairman presents some thoughts on the direction this Committee should be taking during the next year. Because of the increased scope of activities of the Committee it is anticipated that the operating budget for this Committee will need to be revised and the following recommendation is presented for approval.

APPENDIX 2

THIRD PARTY DENTAL PLANS COMMITTEE

RESOLVED:

- 86.17** THAT an additional sum of \$11,000 be added to the budget of the Third Party Dental Plans Committee, for a total revised budget of \$33,000.

ADOPTED

4. Uniform System of Codes & List of Services

The Committee has been working on the Canadian Dental Association list of Codes and Services to attempt to standardize this list and the provincial fee guides and respond to new requests from the provinces. Attached as Appendix 3 are a series of recommended changes.

APPENDIX 3

RESOLVED:

- 86.18** THAT the proposed revisions to CDA Uniform System of Codes & List of Services be approved as amended.

ADOPTED

5. Alternate Delivery of Dental Services

The newly established Committee on Alternative Delivery Systems will work with us to develop resource material to help CDA and the provincial bodies respond to issues related to new modes of financing the delivery of dental services. The first of these is a draft report of the Committee prepared with the assistance of Dr. R.K. House. The Committee recommends the following motion:

THAT CDA develop a brief to be utilized by the provinces to lobby government agencies responsible for insurance regulation to:

APPENDIX 4

- (a) require associations or companies who sell health insurance to be prohibited from becoming providers of health services, hereby creating a conflict of interest,**

THIRD PARTY DENTAL PLANS COMMITTEE

- (b) require those companies selling contract dentist organization plans and independent practice association plans to maintain sufficient reserve funds to ensure that they can meet the commitments of their contract, and
- (c) require that legislation be passed to mandate that prepaid carriers be required to provide equal service for equal payment.

On the advice of the Chairman, Dr. Don E. MacFarlane, the above motion was not considered pending further review by his Committee.

ITEM FOR INFORMATION - NOT REQUIRING BOARD ACTION

6. Sub-Committee on Alternate Delivery Systems

Attached as Appendix 4 are the Terms of Reference of the Sub-Committee on Alternate Delivery Systems.

APPENDIX 5

Respectfully submitted,

Dr. D. E. MacFarlane,
Chairman
Third Party Dental
Plans Committee

ADOPTION OF REPORT

The Board of Governors receives the report of the Third Party Dental Plans Committee with appreciation.

STANDARD DENTAL CLAIM FORM

DUPLICATE FORM ☐

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT. DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN, YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.

IF YOUR PLAN REQUIRES SUBMISSION DIRECT TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2, AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.

*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

STANDARD DENTAL PRE-TREATMENT FORM

Approved by the Ontario Dental Association

		UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.			DAY	MO	YEAR	DAY	MO	YEAR	
ST NAME		GIVEN NAME		D E N T I S T	PHONE NO.			DATE PREPARED			THIS ESTIMATE IS VALID UNTIL		
ADDRESS		APT.											
TY	PROV.	POSTAL CODE											
DENTIST'S SIGNATURE													

ADDITIONAL COMMENTS: Use this space to provide additional information or description pertinent to the treatment plan

Examination (Fees Only)	\$		
Radiographs (Fees Only)	\$		
Diagnostic Service: (Total Fee Only)	\$		L
Hygiene Instructions: (Fee Only)	\$		
Preventive Services:	\$		
Prophylaxis/fluoride: (Fee Only)	\$		
Restorative Services: (itemize surfaces, fees or teeth here.)	\$		
Emergency (Total Fee Only)	\$		L
Endodontic Services: (Total Fee Only)	\$		L
Endodontic Services: Tooth	\$		
Fee per Tooth	\$		
Tooth	\$		
Tooth	\$		
Tooth	\$		
Tooth	\$		
Tooth	\$		
Prosthetic Services: (Total Fee Only)	\$		Drugs
Prosthetic Services: (Total Fee Only)	\$		L
Services including Crowns, Bridges, Dentures: (tooth service, professional fee)	\$		L
(if commercial lab charge)	\$		L
	\$		L
	\$		L
	\$		L
	\$		
	\$		
	\$		

9425

Total Lab Charges \$	
TOTAL ESTIMATE \$	

THIS IS AN APPROXIMATION ONLY.
FINAL LABORATORY CHARGES WILL BE INCLUDED ON CLAIM FORM
SERVICES MARKED (H) WILL BE PERFORMED IN HOSPITAL

THIS SECTION TO BE COMPLETED BY PATIENT									
SUBSCRIBER	NAME								
	EMPLOYER								
	ADDRESS								
GROUP POLICY			CERTIFICATE NO.			SOC. INS. NO.			
PATIENT'S DATE OF BIRTH			DAY	MT	HR	YEAR	RELATIONSHIP TO SUBSCRIBER		
I authorize the release of the information outlined in this treatment form to my insuring company or its agents									
SIGNATURE OF PATIENT (OR GUARDIAN/PARENT)									

APPENDIX 1

EXPLANATORY NOTES FOR REVISED DENTAL CLAIM FORM

The dentist's signature has been removed and in its place there is a Box 8 Office Verification.

In large computer assisted dental practices, the regime of requiring the dentist to sign each and every claim form is a nuisance and time inefficient. This has led to some dental practices having the receptionist sign the claim form, or using a rubber signature stamp, or having the dentist sign pads of blank forms before they are used. These practices negate the reason for the dentist to sign the claim form. In those provinces that still require a dentist's signature it will be placed here. In those provinces that will allow computer generated forms to be computer verified that is all that will be required. Signature stamps would be used here also.

Dental insurance plans can also be compared to other insurance plans. To compare dental insurance to home fire insurance, the insurance holder signs the fire insurance claim form (statement of loss) stating that the fire took place and the cost of repairs was so many dollars. The fire department officials are not required to sign the claim form to verify that they were called to fight the fire.

The patient, who has paid for the insurance coverage, either directly or indirectly, should accept more of the responsibility for the claiming of reimbursement benefits provided by the dental indemnity plan. The essential factor is the dentist is still legally responsible for the proper completion of any forms originating from his dental office with his name on it.

The Claim Form

The industry has now agreed on the organization of their portion of the form. This will mean only one form not a multiplicity from each company.

- 1(a) The unique identification number of the treating dentist is entered here. This identifies the dentist and alerts the insurance company to which provincial suggested fee guide is to be used.
- 1(b) A general practitioner will leave this area blank but a specialist will enter his specialty number. This will alert the processor to which of the suggested specialty fee guides of that province is to be used.

APPENDIX I

-2-

- 1(c) Some dental offices, especially those with computers, have their own numbering system for their patients. This facilitates keeping track of information for that patient. This number should be entered here.
- 2 The patient identification information is entered before the dentist identification information because the insurance industry keeps its information in a system based on the patient.
- 3. The dentist identification section has enough space so that the attending dentist's name is entered first, then, if necessary, the group name is entered on the second line. The dentist's address, postal code and telephone number are entered in the appropriate areas.
- 4. The additional information area has been moved to a more prominent position to encourage more entries by the attending dentist. Note the addition of Duplicate Form. It is utilized to signify the office has filled out a duplicate form.
- 6&7. The patient's release of information authorization section is in the dental area of this form so that the dentist is sure that he has the legal right to allow the release of this information to the insurance carrier. Then the dentist is not in conflict with laws governing the confidentiality of medical records. These will be amalgamated as on old form.
- 8. Item 10 spouses date of birth - utilized only for duplicate coverage.
- 9. This area is similar but not identical to the same area of the old claim form. There are two changes.
 - (a) The procedure code has been placed before the international tooth code. The computers enter procedure codes first. If the procedure is not a covered benefit under the patient's indemnity plan, the rest of the information is not necessary. Also, every dental procedure done has a procedure code number but many procedures may not have a tooth code number (i.e. examination).
 - (b) Every procedure has a dentist's fee but may not have a laboratory charge.

CDA/Feb. 1986

APPROVED BY THE
CANADIAN
DENTAL ASSOCIATION

PART 1 DENTIST

D E N T I S T	NAME	PATIENT'S LAST NAME	GIVEN NAMES
	ADDRESS	ADDRESS	
	CITY, PROV.	CITY, PROV.	
	POSTAL CODE	POSTAL CODE	
	TELEPHONE	UNIQUE I.D. NUMBER	

[illegible]

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED E & OE.	TOTAL SUBMITTED FEE
---	---

DENTIST'S SIGNATURE				DATE	DAY	MONTH	YEAR

FOR DENTIST'S USE ONLY FOR ADDITIONAL INFORMATION RE DIAGNOSIS
PROCEDURES OR COMPLICATIONS AND SPECIAL CONSIDERATIONS

[illegible]

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY OR ITS AGENTS.	I HEREBY ASSIGN BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM.
---	---

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) _____
SIGNATURE OF SUBSCRIBER

FOR PLAN ADMINISTRATOR USE ONLY

[illegible][illegible]**PART 2 INSURED/SUBSCRIBER**

**COMPLETE THIS PART BEFORE TAKING
THE FORM TO YOUR DENTIST'S OFFICE**

1 PATIENT RELATIONSHIP TO INSURED DATE OF BIRTH

IF CHILD AGE 21 OR OVER INDICATE STUDENT ☐ HANDICAPPED ☐

2 ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE
OR DENTAL PLAN? ☐ NO ☐ YES POLICY NUMBER _____

NAME OF INSURING AGENCY _____

3 IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES

GIVE DATE AND DETAILS

4 IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

5 IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES

GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT

6 I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE

7 INSURED NAME (PLEASE PRINT) _____

ADDRESS _____

DATE	DAY	MONTH	YEAR	SIGNATURE
------	-----	-------	------	-----------

PART 3 POLICYHOLDER

1	POLICY NUMBER	
	SUFFIX	ACC/DIV
2	NAME OF INSURED	
3	SIN	
4	CERT NO	

	DAY	MONTH	YEAR
5. DATE INSURED			
6. DATE DEPENDENT INSURED			
7. DATE TERMINATED			

8 IS CLAIM BEING MADE FOR WORKMEN'S COMPENSATION BENEFITS? ☐ NO ☐ YES

9 POLICY HOLDERSIGNATURE OF AUTHORIZED OFFICIAL

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

DATE	DAY	MONTH	YEAR
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ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ADDENDUM TO APPENDIX I EXECUTIVE COUNCIL REPORT TO
CDA BOARD OF GOVERNORS INTERIM MEETING
APRIL 4-5, 1986

Signature on File

Enclosed is a description of "Signature on File". This should have been included in the Board Book with the Third Party Dental Plans Committee Report. It goes along with the CDA Standard Dental Claim Form.

There has been a lot of requests for changes that will allow batch processing of claims. If this is to be efficient the patient's signature is the stumbling block. Moving to a "Signature on File" system so that the patients are informed about the process and agree in advance is one solution. This will allow the computer to print "Signature on File" in the appropriate box on the form.

Dentist's Signature (Office Verification)

Many dental plans now accept signature stamps. Our Committee feels moving to an unsigned form for a computer generated form is no different. It is the Committee's belief that in the near future (3 to 5 years) industry will be looking toward electronic transmission of data via telephone, an example is Envoy 100, which does this now with electronic mail. This will come about because of the significant cost savings both in the dental office and at the dental plan end. The proposal for no dentist's signature on the revised form will allow the profession to determine if this works and what the problems are prior to making the shift to electronic data transfer. The Committee believes it should be up to each province to decide whether "Signature on File" and "Dentist's Signature" is required.

CDA-April, 1986

Third Party Dental Plans Committee

THE DENTIST'S SIGNATURE (OFFICE VERIFICATION)

Signature on File

In order for claims forms to be accepted with "signature on file" printed in the sections where the patient/subscriber is to sign, it is necessary for the dental office to establish a system of signature cards with the following statements.

1. Authorization to Release Information

You are authorized to provide the dental plan(s), claim administrator(s) and consulting dental care professionals, information concerning dental care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

This authorization is valid for the term of coverage of the policy or contract in force on this date, or for one year, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient or Authorized Person's
Signature

Date

2. Authorization to Pay Benefits Directly to the Dentist

I hereby authorize payment directly to (dentists' name) of the dental benefits otherwise payable to me.

Signed (Insured Person)

Date

Signature is valid for one year from the above date, unless revoked by me at any earlier date.

If benefit is to be paid to the patient, a signature card is not required and the section of the claim form is left blank.

3. Revocation of Authorization to Pay Directly

The Patient or insured person has the right to revoke the authorization to have the dental plan pay the dentist directly. It is preferred that the insured inform the dentist of a revocation directly. If the dentist or the insured notifies the carrier of a revocation, such a notice should be in writing. If the revocation is made to the carrier by the insured, the carrier should notify the dentist.

The Dentist's Signature (Office Verification)

-2-

If payment has been received by the dentist from the carrier after the dentist has been notified that the authorization to pay directly has been revoked, the dentist should do one of the following:

- (a) return the cheque to the carrier
- (b) deposit the cheque and issue a new cheque to the carrier for the amount involved

The signature on file cards are subject to spot audit from time to time. If the carrier requests a photocopy of the signature on file cards they must be provided.

4. Hold-Harmless Statement

It is recommended that the following "hold harmless" statement be transmitted to the carrier by those dentists utilizing signature on fil claim submissions.

If authorization to pay third party benefits are indicated on this form, appropriate authroizations to pay, signed by the insured/beneficiary, and signature of patient or legal guardian covering authorization to release information are on file. Determination as to the release of dental and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The dentist agrees to save harmless indemnity and defend any insurer who makes payment in reliance upon his certification, from and against any claim to the insurance proceeds when in fact no valid "Authorization to Pay" benefits to the dentist was made.

5. Dentist and Carrier Responsibilities

- (a) Authorization to release information and to pay should be verified by the dentist each time the patient has an appointment. A new signature(s) must be obtained and dated when the dental plan carrier is changed.
- (b) Carriers and administrators have the right to request and receive proof that valid signatures are maintained in the dental office.
- (c) The dentist is responsible for the maintenance and integrity of claim submission, even though the actual processing may be performed by a service bureau. The accuracy of the patient/beneficiary section of the dental form is of primary importance. This responsibility includes the refund of any payment issued as a result of inaccurate records or fraudulent practices.

5. Dentist and Carrier Responsibilities (cont'd.)

- (d) Signatures on file should be renewed annually unless revoked by the patient/insured.
- (e) The method of transmittal of the "hold harmless" statement to the carrier is left to the option of the dentist. Any of the following would be appropriate:
 - (i) attachment of a separate form to the claim form
 - (ii) computer requested statement printed on a claim form
 - (iii) a letter sent to the carrier by the dentist notifying them for each patient involved.
 - (iv) affix adhesive-backed sticker to claim form.

CDA-Mar. 1986

NEW DIRECTIONS FOR THE THIRD PARTY DENTAL PLANS COMMITTEE

The entire area associated with alternative delivery systems is very rapidly becoming a major concern of Canadian dentists.

Initially, there has been a rapid expansion of retail dentistry and some limited union clinic involvement. Within the past year there have been a number of significant initiatives:

- (a) Canadian Federation of Labour proposed to open clinics across the country.
- (b) Groups - e.g. Future Focus are attempting to set up Contract Dentist Associations - capitation.
- (c) Mutual of Omaha has approved and may have already entered into an agreement with a large retail dentistry operation to provide reduced fee services.
- (d) The capitation approach is being looked at by a number of insurers.
- (e) In B.C. C.U. & C. Health Services a large not-for-profit dental plan is planning to open a clinic or clinics.

The traditional delivery system for dental care is being challenged in many ways - not for lack of service or lack of excellence but rather as a cost cutting approach. To adequately prepare Canadian dentists to assess such developments and to develop a balanced view about the many different approaches, it is essential that CDA set aside more funds in its budget for the alternative delivery systems section of the Third Party Plans Committee.

In addition, the Committee requires a great deal more staff time than is currently available. It is the Committee's opinion that a senior staff person, ideally a dentist, with a background in communications and the field of development of educational materials is required, with appropriate secretarial support and a budget for materials and travel.

With this support the Third Party Committee would hold seminars across the country to train groups of dentists about the alternative delivery systems - their strengths, weaknesses, the risks to dentists. It would train them to be able to teach other dentists how to communicate with employer and employee groups. It would develop expertise in each province to offer advisory service to employer and employee groups on the most cost effective dental plans - and thus help groups to assess what they are buying.

In December, 1985 I had a visit with the staff of the Council on Dental Programs at the ADA in Chicago. This Council has a large staff and a budget of approximately \$500,000.00. This is targeted to meet the challenges the dental profession is faced with in the U.S. Alternative approaches have been on the scene in the U.S. for a few years. They have developed a number of programs to respond and are pursuing very aggressively other new resources. Many of the existing programs have met with excellent success. Additionally, I was told the budget will be doubled this year.

ADA was very co-operative and gave us a great deal of information and printed materials and their co-operation is appreciated.

The ADA Council on Dental Programs has a significant staff:

Secretary to the Council on Dental Care Programs - Dr. Jack O'Donnell
Assistant Secretary to the Council on Dental Care Programs - David Tice
A second Assistant Secretary to the Council on Dental Care Programs
Secretarial support for these people.

Some of the programs they are involved with include:

- (a) Preparing and distributing educational materials on all the different alternate delivery systems. e.g. pamphlets booklets, articles in the journal and newsletter.
- (b) Giving seminars throughout the US on the alternatives - especially capitation and contract dental associations.
- (c) Giving seminars on direct reimbursement as an alternative for indemnity dental plans.

Both (b) and (c) are designed to train a committee of dentists in the local area so they can train other dentists to communicate with the media and with employee groups and employees.

The CDA should also be providing this type of program. We can borrow those things that are appropriate and develop the additional resources we require. To adequately take on this type of program it would be necessary for the Third Party Dental Plans Committee to have a great deal more staff support. In particular, an individual with communication skills and the ability to develop educational materials (both written and visual aids) is required.

This staff person along with the Third Party committee would run seminars in each of the provinces to educate interested dentists on the alternative delivery systems and how to communicate with employee and employer groups. The resulting nucleus of trained dentists would then be able to give seminars to others in their province.

It will also be essential to increase the activity level of the Committee. There will be a need for 6 days of meetings (3 - 2 day meetings of the Third Party Committee) and in addition the Alternative Delivery Sub-Committee will need to meet for 4 days. The following augmented budget is necessary to support such increased activity:

1986 Revised Budget

6 - 2 day meetings	\$16,000
4 - 1 day meetings of Alternative Delivery Sub-Committee	8,000
4 - day meetings by Chairman with outside agencies	4,000
Consultative support services - e.g. Ron House Legal	5,000
Printing & Mailing	<u>20,000</u>
	\$53,000

This year's budget of \$22,000 had to be submitted before the Committee was fully aware of the scope of activity level necessary in the immediate future.

Respectfully submitted,

Dr. D. E. MacFarlane
Chairman
Third Party Dental Plans
Committee

THIRD PARTY DENTAL PLANS COMMITTEE
REVISIONS TO CDA UNIFORM SYSTEM OF CODES
AND LIST OF SERVICES

INTERIM BOARD MEETING

APRIL 4-5, 1986

THIRD PARTY DENTAL PLANS COMMITTEE

PROPOSED REVISIONS TO CDA UNIFORM SYSTEM OF CODES & LIST OF SERVICES FOR PRESENTATION TO INTERIM BOARD OF GOVERNORS MEETING APRIL 1986

CURRENT WORDING

01000-09999 DIAGNOSTIC REVISIONS

ONTARIO

02135 Five Occlusal Films
02136 Six Occlusal Films

10000-19999 PREVENTIVE REVISIONS

ONTARIO

13600 Changing the Wording of Procedure as follows:
"Caries control (Removal of Carious Lesions and placement of sedative dressings)" to become more concise as
"Caries/Trauma/Pain Control (Removal of Carious Lesions or Existing Restorations and Placement of Sedative/Protective Dressing)".

PROPOSED CHANGES

02100 Intraoral-Periapical-Complete Series (Including Bitewings) should now become more precise and read
"INTRAORAL-PERIAPICAL-COMPLETE SERIES (INCLUDING BITEWINGS) MINIMUM 16 FILMS.

02101 Should also include in its description - "MINIMUM 12 FILMS".

02304 Postero-Anterior and Lateral Skull and Facial Bone Survey - Four Films, should be more concise and be redefined as "SINUS EXAMINATION SURVEY - MINIMUM FOUR FILMS - IDENTIFIED AS (1) WATERS (2) CALWELL (3) LATERAL SKULL (4) BASAL".

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PROPOSED REVISIONS TO CDA UNIFORM SYSTEM OF CODES & LIST OF
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20000-29999 RESTORATIVE REVISIONS AND ADDITIONS

BRITISH COLUMBIA AND COMMITTEE

A brief summary for this major reorganization and revision is necessary. We as the Third Party Committee feel that the section pertaining to the new bonding procedures has become a basic technique in most modern dental practices. The codes must reflect exact procedures now being utilized because of the bonding mechanisms. Therefore a more finite coding is necessary. We have dropped any coding differences for light polymerized versus autopolymerized, and have dropped the separate code for silicates. We feel that the existing coding system, reflects only differences in material. The techniques involved are the same. The first major change comes in the naming of the classification "23000". This will now be all encompassing and be categorized as:

23000 TOOTH COLOURED RESTORATIONS

Further to the coding, this explanation is needed to define the total reorganization of the coding numbers:

23000 Defines the classification

23100	Subclassification -	permanent restorations	anterior	tooth	coloured
23200	Subclassification -	permanent restorations	posterior	tooth	coloured
23300	Subclassification -	Deciduous restorations	anterior	tooth	coloured
23400	Subclassification -	Deciduous restorations	posterior	tooth	coloured

A standardized coding of the next digit or the "TEN" position (i.e. second position from the right) has also been established as follows:

A "O" in a ten position denotes "Non-Acid Etch Techniques".

A "1" & "2" in a ten position denotes "Acid Etch/Bonding" Techniques.

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23100	PERMANENT ANTERIOR TOOTH COLOURED RESTORATIONS
23101	Tooth Coloured Non Acid Etch Class I or V
23102	Tooth Coloured Non Acid Etch Class III
23103	Tooth Coloured Non Acid Etch Class IV
23104	Tooth Coloured Non Acid Etch Double Class IV (Involving Mesial and Distal Incisal)
23105	1 Surface Anterior/Complete Incisal Edge (Class VI)
23106	2 Surface (Continuous)
23107	3 Surface (Continuous)
23108	4 Surface (Continuous)
23109	5 Surface (Continuous)
23111	Tooth Coloured Acid Etch/Bond Class I or V
23112	Tooth Coloured Acid Etch/Bond Class III
23113	Tooth Coloured Acid Etch/Bond Class IV
23114	Tooth Coloured Acid Etch/Bond Double Class IV (Including Mesial and Distal Incisal)
23115	1 Surface Ant-Complete Incisal Edge (Class VI)
23116	2 Surface (Continuous)
23117	3 Surface (Continuous)
23118	4 Surface (Continuous)
23119	5 Surface (Continuous)
23121	Prefabricated Veneer Applications - Resin Bonded - Acid Etch (Laboratory Procedures Not Included)
23122	Non-Prefabricated Veneer Applications - Resin Bonded - Acid Etch

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23200 PERMANENT POSTERIOR TOOTH COLOURED RESTORATIONS

- 23201 Posterior Tooth Coloured Non Acid Etch - 1 Surface
- 23202 Posterior Tooth Coloured Non Acid Etch - 2 Surface
- 23203 Posterior Tooth Coloured Non Acid Etch - 3 Surface
- 23204 Posterior Tooth Coloured Non Acid Etch - 4 Surface
- 23205 Posterior Tooth Coloured Non Acid Etch - 5 Surface

- 23211 Posterior Tooth Coloured Acid Etch/Bond - 1 Surface
- 23212 Posterior Tooth Coloured Acid Etch/Bond - 2 Surface
- 23213 Posterior Tooth Coloured Acid Etch/Bond - 3 Surface
- 23214 Posterior Tooth Coloured Acid Etch/Bond - 4 Surface
- 23215 Posterior Tooth Coloured Acid Etch/Bond - 5 Surface

23300 DECIDUOUS ANTERIOR TOOTH COLOURED RESTORATIONS

- 23301 Deciduous Tooth Coloured Non Acid Etch - Class I or V
- 23302 Deciduous Tooth Coloured Non Acid Etch - Class III
- 23303 Deciduous Tooth Coloured Non Acid Etch - Class IV
- 23304 Deciduous Tooth Coloured Non Acid Etch - Double Class IV (Involving Mesial and Distal Incisal)
- 23305 Deciduous 1 Surface/Complete Incisal Edge (Class VI)
- 23306 Deciduous 2 Surface (Continuous)
- 23307 Deciduous 3 Surface (Continuous)
- 23308 Deciduous 4 Surface (Continuous)
- 23309 Deciduous 5 Surface (Continuous)

- 23311 Deciduous Tooth Coloured Acid Etch/Bond Class I or V
- 23312 Deciduous Tooth Coloured Acid Etch/Bond Class III
- 23313 Deciduous Tooth Coloured Acid Etch/Bond Class IV
- 23314 Deciduous Tooth Coloured Acid Etch/Bond Double Class IV (Including Mesial and Disal Incisal Edge)
- 23315 Deciduous 1 Surface/Complete Incisal Edge (Class VI)
- 23316 Deciduous 2 Surface (Continuous)
- 23317 Deciduous 3 Surface (Continuous)
- 23318 Deciduous 4 Surface (Continuous)
- 23319 Deciduous 5 Surface (Continuous)

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23400 DECIDUOUS POSTERIOR TOOTH COLOURED RESTORATIONS

- 23401 Deciduous Posterior Tooth Coloured Non Acid Etch - 1 Surface
- 23402 Deciduous Posterior Tooth Coloured Non Acid Etch - 2 Surface
- 23403 Deciduous Posterior Tooth Coloured Non Acid Etch - 3 Surface
- 23404 Deciduous Posterior Tooth Coloured Non Acid Etch - 4 Surface
- 23405 Deciduous Posterior Tooth Coloured Non Acid Etch - 5 Surface

- 23411 Deciduous Posterior Tooth Coloured Acid Etch/Bond - 1 Surface
- 23412 Deciduous Posterior Tooth Coloured Acid Etch/Bond - 2 Surface
- 23413 Deciduous Posterior Tooth Coloured Acid Etch/Bond - 3 Surface
- 23414 Deciduous Posterior Tooth Coloured Acid Etch/Bond - 4 Surface
- 23415 Deciduous Posterior Tooth Coloured Acid Etch/Bond - 5 Surface

23123, 23124, 23125, 23126, 23127, 23128, 23129 eliminated for reasons given in preamble, i.e. we do not differentiate light cure versus autocure. A similar analogy is with Amalgam Restorations, we do not differentiate types of amalgams as to their property differences. All amalgams are placed and handled as silver restorations.

PROPOSED CHANGES

- | | | |
|-------|-----------------|--------------------------|
| 27400 | Series of Codes | Preformed Steel Crowns |
| 27420 | Series of Codes | Preformed Plastic Crowns |

An explanation as to the changes being made in the above codes is necessary.

The 27000 classification in the CDA Guide refers or infers permanent full crown coverage as in 27210, being a Porcelain Bonded Crown. The Stainless Steel and Preformed Plastic Crowns are actually alternatives to the large amalgam restorations such as a five surface amalgam with undermined cusps etc. For Third Party clarity, i.e. Dental Third Party Claims by the dentist, we must distinguish between actual Crown and Bridge type procedures in relation to full coverage prefabricated restorations. If we do not correct this code, insurance claims are handled under different sections of the coverage available and patients requiring full coverage type procedures of this nature are having claims rejected. If, however, a Pin Amalgam of Five Surfaces with Shod Cusps is claimed for the Third Party carrier will provide coverage, without question.

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Therefore the following section in our guide is being created and the 27400-27425 classification is being dropped.

22000 FULL COVERAGE PREFABRICATED RESTORATIONS

22200 Metal Prefabricated Restorations - Primary Teeth

22210 Primary Anterior

22211 Primary Anterior - Open Face

22220 Primary Posterior

22221 Primary Posterior - Open Face

22300 Metal Prefabricated Restorations - Permanent Teeth

22310 Permanent Anterior

22311 Permanent Anterior - Open Face

22320 Permanent Posterior

22321 Permanent Posterior - Open Face

22400 Plastic Prefabricated Restorations - Primary Teeth

22410 Primary Anterior

22420 Primary Posterior

22500 Plastic Prefabricated Restorations - Permanent Teeth

22510 Permanent Anterior

22520 Permanent Posterior

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The Committee recommends that the following codes be dropped to create uniformity across the country and eliminate dual description and codes within the CDA Uniform System of Codes and List of Services.

21201 PERMANENT 1 SURFACE
 21202 PERMANENT 2 SURFACE
 21203 PERMANENT 3 SURFACE
 21204 PERMANENT 4 SURFACE
 21205 PERMANENT 5 SURFACE

These codes are only in use in Alberta and Saskatchewan and it will be strongly recommended to these provinces that the codes be dropped. These provinces can easily create the same fee structure for the existing codes in use throughout the rest of Canada.

21211, 21312, 21213, 21214, 21215, FOR BISCUPIDS AND ANTERIORS
 21221, 21222, 21223, 21224, 21225, FOR MOLARS

REQUEST FOR ADDITION - ONTARIO

26500 ONLAY, PORCELAIN

REQUEST FOR ADDITION NEWFOUNDLAND

62711 Provisional Acid Etch Bridge - Using patients own tooth or plastic/porcelain tooth.

30000-39999 ENDODONTICS

ONTARIO

39910 Changed to read "TREPHINATION THROUGH NATURAL CROWN INTO CANAL".

39911 TREPHINATION THROUGH METAL OR PORCELAIN CROWN INTO CANAL

40000-49999 PERIODONTICS

ONTARIO

49010 TMJ Intra Oral Appliance
 49011 Periodic Maintenance, Adjustments and Repairs to TMJ Appliance (Laboratory Procedures not Included)
 42103 Description of "Flap Approach with Treatment of Osseous Defects with Implants - Single Site" be changed to:

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FLAP APPROACH WITH TREATMENT OF OSSEOUS DEFECTS WITH GRAFTS - SINGLE SITE

42104 Change description of "Osseous Grafts - Multiple site including Flap Entry and Closure" to:

FLAP APPROACH WITH TREATMENT OF OSSEOUS DEFECTS WITH GRAFTS - MULTIPLE SITES

BRITISH COLUMBIA

42007 GINGIVAL FIBER INCISION FIRST TOOTH

42008 GINGIVAL FIBER INCISION EACH ADDITIONAL TOOTH

50000-59999 PROSTHETICS REMOVEABLE

ONTARIO

55105 Replacement of "Fractured, Worn or Lost" tooth or teeth on a partial or full denture (in addition to 55101 through 55104 and 55201 through 55204). It exists now as only Fractured or Lost Teeth.

52500, 52510, 52520 Addition of "(TOOTH BORNE)" in parenthesis.

60000-69999 PROSTHETICS - FIXED

MANITOBA

63300 RECONTOURING CROWNS

MANITOBA, ONTARIO AND NOVA SCOTIA

66700 Be standardized in usage as "PROCELAIN REPAIR-FIXED BRIDGE - PER TOOTH (DIRECT)"

COMMITTEE RECOMMENDS:

66701 Porcelain Repair - Fixed Bridge/Tooth - Indirect (Laboratory Procedures not Included)

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26701 Presently exists as "PORCELAIN REPAIR - FIXED BRIDGE"

COMMITTEE RECOMMENDS:

26700 Porcelain Repair Single Crown - Direct

26701 Porcelain Repair Single Crown - Indirect (Laboratory Procedures not Included)

70000-79999 ORAL SURGERY

ONTARIO

74412 Excision of Cyst in Conjunction with Tooth Removal

75108 SURGICAL EXPLORATION - SOFT TISSUE INTRA ORAL

Ontario applied for 75208. However, a 1 would designate uniformity as to Intra Oral and a 2 represents Extra Oral procedures. Therefore, the 75108 rather than 75208.

75112 SURGICAL EXPLORATION - HARD TISSUE - INTRA ORAL

Ontario applied for 75212 and again a 1 rather than a 2 should designate Intra Oral.

75214 SURGICAL EXPLORATION - HARD TISSUE - EXTRA ORAL

The following codes have been applied for by Ontario to aid in the OHIP claim procedures for Oral Surgery. OHIP will not allow the dentists to use physician's procedure codes for dental procedures as they relate to plastic surgery related procedures. Therefore these new codes have been requested.

76640 Zygomatico-Maxillary Complex Fracture - Dislocation - Closed Reduction.

76641 Zygomatico-Maxillary Complex Fracture - Dislocation - Open Reduction

76730 Exploration of Orbital Blowout Fracture

76740 Exploration of Orbital Blowout Fracture and Reconstruction with Insertion of a Subperiosteal Implant

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77470 Total Dento-Alveolar Osteotomy of the Mandible

Ontario has applied for 77461. This is a different procedure than the 460 series of procedure codes. 77451-452 deals with the Anterior Segmental Osteotomy of the Mandible and the 460 series deals with the Posterior Osteotomy of the Mandible. Therefore a total Osteotomy should have a section unto itself as does the Anterior and Posterior. Thus the code 77470 is more appropriate and allows for variations of this procedure in the future if they should be necessary.

77630 UNILATERAL CLEFT LIP REPAIR

77640 RECONSTRUCTION WITH LIP SWITCH FLAP

77645 COMPLEX RECONSTRUCTION OR REVISION

78230 Plication of the Posterior Attachment of the Disk of the T.M.J. in cases of Internal Derangement.

78410 Reconstruction of the Glenoid Fossa, Zygomatic Arch and Temporal Bone (Obwegeser Technique)

79220 Suture of a Major Peripheral Nerve - Epineural

79230 Suture of a Major Peripheral Nerve - Fascicular

79240 Use of an Operating Microscope in Suturing of Major Peripheral Nerves

ONTARIO ADDITION

78700 Orthopedic rehabilitation appliance splints (Maxillary or Mandibular)

Ontario has requested 78500. This code already exists as Arthrocentesis. We have applied an unused subclassification of the guide, since the requested procedure is of a totally different nature than the requested code.

90000-99999 ADJUNCTIVE GENERAL SERVICES

COMMITTEE RECOMMENDATION

99350 IN-OFFICE LABORATORY PROCEDURES (ALREADY EXISTS)

99360 COMMERCIAL LABORATORY CHARGES

This is requested for computerized entries which require separate codes for separate descriptions.

March 1986

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52122 CUSIL TYPE PARTIAL DENTURE - MAXILLARY

52123 CUSIL TYPE PARTIAL DENTURE - MANDIBULAR

65500 Add to the existing description "(MARYLAND, ROCHETTE, TYPE
BRIDGE)"

Draft Report of
The Third Party Dental Plan Committee
on the
Cause, Analysis and Response to
Alternatives to the
Traditional Private Practice

Prepared with the Assistance of
R. K. House, Ph.D.

January 1986

Section I

THE CAUSES OF INTEREST IN ALTERNATIVES TO THE TRADITIONAL PRIVATE PRACTICE

Interest in alternative modes of delivering dental services by the private sector has increased dramatically in the past few years. This is a new development.

Throughout North America during the 1960's and 1970's there was considerable interest in the development of government sponsored alternatives to private practice dentistry. This interest was an informed response to certain perceived problems in dentistry, namely:

- 1) failure to extensively use auxiliaries,
- 2) an insufficient number of dentists,
- 3) low utilization rates among parts of the population,
and
- 4) costs.

Interest in government sponsored dental plans or delivery systems has waned, partially because some of the traditional "problems" of dentistry have been solved and a new set of "problems" has emerged. The decline of interest in government programs has been replaced by interest in a variety of private sector plans, schemes or proposals to develop alternatives to the traditional fee-for-service private practice. Just as the genesis of the interest in government programs in the 1960's and 70's could be found in publicly perceived problems of dentistry so too can the interest in alternative private sector delivery systems be found in the contemporary problems of dentistry. If the perceived problems in

dentistry were to change once again then interest in these private sector alternatives would likely recede.

The major contemporary problems that give rise to interest in private sector alternatives are:

- i) an abundant or excess supply of dentists
- ii) a rapidly increasing number of auxiliaries
- iii) the high capital costs of establishing a practice
- iv) changing dental attitudes and the opportunity to mass market dentistry
- v) the perceived high costs and high profitability of dentistry
- vi) the potential collapse of dental insurance schemes
- vii) fears of abuse, overtreatment, overcharging and dual fee schedules in the private practice

Unfortunately these "problems" for dentistry afford opportunities to entrepreneurs - opportunities that have not hitherto existed in dentistry. If some of the traditional aspects of dentistry are to be preserved over the next decade it is important to appreciate how the current "opportunities" provide motivation for the development of private sector alternatives to the traditional fee-for-service practice.

i) THE ABUNDANT OR EXCESS SUPPLY OF DENTISTS

Historically, a shortage of dentists meant that individual dentists had considerable bargaining power. This bargaining or market power was so real and so pronounced that it was not profitable for an entrepreneur to attempt to establish an alternative to private practice. Individual dentists would have demanded compensation at least equivalent to that

which they would have earned if they had gone into private practice. If they had not received it they would have readily entered private practice. Entry into private practice was easy, success was virtually guaranteed. Thus the dentist historically had the bargaining power to retain the "profits" now sought by the entrepreneurs. In the 1980's this is no longer true.

New graduates recognize that success in private practice is not assured. Many are willing to consider alternatives to private practice and as a result the individual dentist has lost much of his bargaining power. Because of the fear of the risks that developing a private practice entails, entrepreneurs who can diminish the risk either by spreading it over a large number of practice sites or by having access to a "captured" patient pool (i.e., unions or corporations) are able to successfully negotiate wage concessions from individual dentists. The apparent shift of bargaining power to the entrepreneurs now makes it possible for the entrepreneur to see the prospect of high returns to his investment.

The entry of these entrepreneurs accelerates the development of competition in dentistry. In spite of the current enthusiasm for competition, the traditional view has been that the role of competition in the professions and perhaps most especially in the caring professions, is at best limited. Nevertheless, the development of market competition will lead to downward pressure on fees or fee increases, and on net incomes. This is an inevitable consequence of increased manpower and productivity. Declining profitability will increase the real risks both for the private practice dentist and for

the private sector alternatives where there are no offsetting factors such as a captured patient pool. It must be recognized that the captured patient pool is a means of minimizing business risk, but, as is discussed below, the opportunity to reduce business risk in this way is not necessarily in the best interest of the patient.

ii) RAPIDLY INCREASING NUMBERS OF AUXILIARIES

Under typical fee structures, the employment of auxiliaries able to perform intra-oral procedures is a source of income to the dentist. Part of the reason for this has been the slow evolution of changes in the fee structure of the private practice. Often the fees charged for services provided by auxiliaries still reflect an underlying assumption that the service is provided by a dentist even though the wages of the auxiliaries are significantly less than those of a dentist. This, coupled, with the fact that dental care requirements are shifting towards services provided by auxiliaries, also creates an inducement to develop alternative practice systems that allow the entrepreneur to capture the excess earnings of the auxiliary or to pass some savings back to the patient. For example, it appears that in at least one commercial dental chain the dentist's remuneration is based on his own productivity but he does not share in the earnings of the auxiliaries. Entrepreneurs see the opportunity to become the de facto employers of auxiliaries as a commercial opportunity. It is an opportunity that is afforded to them through the increased public acceptance of auxiliaries, moderation in what constitutes acceptable "supervision" of auxiliaries, and of course, the structure of current fee guides.

The potential evolution of some of the alternatives to the private practice must cause concern over the possibilities that these alternatives could become the forerunners of virtually independent auxiliary practices, particularly in offering the services of hygienists. Virtually independent auxiliary practices represent the most radical departure from traditional dental practices.

iii) HIGH CAPITAL COSTS OF ESTABLISHING A PRACTICE

The real costs of establishing a practice have increased at a time when the success of a new practice has become more uncertain. The business risk of the private practice has therefore increased and this has caused young, risk-averse dentists to be attached to alternative less risky modes of practice. Organizations that have funds in excess of their current needs and a direct interest in the provision of dental care, see the opportunity to "invest" in dental facilities as a profitable undertaking which also provides potential control of future health and benefit costs. Some corporations, unions, insurers and labour organizations fall into this category.

iv) CHANGING DENTAL ATTITUDES AND OPPORTUNITIES TO MASS MARKET DENTISTRY

The available evidence suggests that a significant proportion of the population is now accustomed to receiving regular dental care. This is in marked contrast with the 1960's in which a relatively small part of the population sought regular care. Now that dentistry is an important "consumer good" various forms of advertising can be used to attempt to capture market share. The cost effectiveness of advertising is slight

in markets in which the supply side is highly fragmented. However, the economics of advertising change rapidly when a national or regional image can be marketed. It is already evident that national chains do benefit from forms of national exposure or advertising that are currently unavailable to solo practitioners or small groups. Entrepreneurs who are now building "chains" of dental practices likely see the possibility of effective advertising as one of their major advantages in the competitive battle with traditional practitioners. Young graduates, who are uncertain about how to build a practice probably see the marketing advantages of some of the alternate delivery systems as an advantage if they work for a chain, and a source of unfair competition if they attempt to establish their own practices. The fact that some alternative delivery systems may have "client panels" guarantees a patient pool and agreements, contracts, or delivery systems that can deliver a captured patient pool are the most effective forms of marketing.

v) PERCEIVED HIGH COST AND PROFITABILITY OF DENTISTRY

The attitude that dentistry is expensive and highly profitable appears to be well entrenched and it is therefore natural that entrepreneurs would attempt to tap this market. Commonly one hears the opinion that the costs of dentistry could be substantially reduced if dentists were "put on reasonable salaries". Some of the alternative delivery systems are intent upon reducing dental costs by reducing the dentist fees or income.

The professional ethic of not engaging directly and publicly - through advertising - in price competition is an attractive feature of the dental market to the entrepreneur who is not burdened by these attitudes. The entrepreneur feels less threatened by the prospect of a price war. The relatively short depreciable life of the required equipment or assets also allows for fairly effective capital budget planning in a market in which "price" and demand are not perceived as being very volatile. These again are attractive characteristics from the point of view of the investor.

vi) POTENTIAL COLLAPSE OF DENTAL INSURANCE PROGRAMS

With high utilization rates and major reductions in the requirements for restorative care and hence a relatively straight forward estimate of the continuing cost of examinations and preventative care, dentistry is losing the characteristics of an "insurable" phenomenon. In fact, it would appear that premiums in many plans are more akin to mere prepayment for regular dental care rather than an insurance premium. Recognizing - perhaps not explicitly - that dental insurance is no longer "insurance", employers and unions have turned their attention to possible ways of reducing a virtually certain expense. In the case of some union groups or union affiliated groups, this is the route they must go if they are to have any future role in the provision of dental benefits.

As utilization approaches 100% and the required levels of diagnostic and preventive care are clearly identified and as dentists charge plan members and private individuals the same fees, the existence of a third

party merely adds an unnecessary administrative expense. Thus, for some of the existing "third parties" their survival depends upon either negotiating fee reductions for their members, or becoming direct providers. There are, of course, some currently attempting to do both.

vii) FEARS OF ABUSE, OVERTREATMENT, OVERCHARGING AND DUAL FEE SCHEDULES IN THE PRIVATE PRACTICE

A commonly voiced but undocumented form of abuse is the alleged practice of a dual fee schedule - one for those with dental insurance and a lower one for those without insurance.

Some insurers believe this happens. This belief provides an incentive to negotiate a fee reduction for plan members. In order to develop a bargaining position plan operators can offer, for example, a "captured patient pool" and avail themselves of dental services provided under contract. However, the most direct way to relieve themselves of this supposed abuse is to hire dentists on salary and become direct providers of the service.

A second emerging concern of plan administrators is a fear of "overtreatment" or unnecessary treatment. This may take a variety of forms:

- the provision of an expensive service when a less costly service would have served as well,
- the provision of services that are largely cosmetic, and
- the provision of services that are clinically unnecessary.

Unfortunately, some patients also believe that they are subject to these abuses. The alleged cause of these abuses is excess manpower and the

individual dentist's attempt to maintain his income in the face of decreasing business.

Again, the most obvious way of escaping these abuses is to become a direct provider but when this is infeasible or impractical, the alternative of contracting for services on a competitive basis has been and will continue to be attempted.

Section II

THE ARCHITYPICAL RESPONSES OF THE PRIVATE SECTOR

The "problems" in dentistry which have arisen in the past few years have opened up opportunities for an entrepreneurial response. This is leading to experimentation or proposals for experimentations that are new and in many cases threatening to the traditional dental practice. In this section we consider the generally distinct types of response and identify the potential threats that they pose to the patient or dentist. In the subsequent section we examine how organized dentistry may respond to curb potential abuses.

i) THE INSTITUTIONALLY OWNED CLOSED PANEL

For the purpose of this discussion we define the "Institutionally Owned Closed Panel" as a situation in which the dental practice is owned by an institution such as a union, corporation or benevolent society and the services rendered by the practice are offered to a restricted group such as the members of a union, employees of a company or membership of a society. The recipient's dental benefits are available only through the "owned practice". Typically the dentists may be on salary or work on a piece rate or a percentage of "total billings".

The institutionally owned closed panel exhibits many objectionable characteristics from the patient's and dentist's points of view and a few very attractive features from the entrepreneur's or institution's point of view.

The first, and one of the most objectionable features is that the patient has no choice of dentist. He is limited to those on the closed panel. The converse of this is also true - the dentist is in no position to "choose" his patients. Since dentistry is truly a personal service it is important that both the patient and the dentist are able to maintain a harmonious relationship. In fact, the importance of this relationship in dentistry is probably much more critical than the relationship between a physician and a patient.

The reason for the need for harmony is that one of the major deterrents to seeking regular dental care is "fear of the dentist". The dentist and his staff play a key role in motivating the patient to seek regular and complete treatment.

The fact that a patient is "captured" by a closed panel also exacerbates one of the historic criticisms of dentistry as a profession. Many other professionals - physicians in hospital, lawyers in courts and so forth work in the presence of their peers and a constant source of motivation for some professionals is to earn and maintain the respect of their peers who see them at work. By contrast, dentists historically have worked in relative isolation from one another, but their patients have been mobile and to a limited extent their patients carry the evidence of their competence. Dentists know that judgement, even if unspoken, may be passed upon them. The closed panel may intensify the problem of professional isolation because the patient loses his mobility and the closed panel dentist works in an environment in which his peers outside his practice will have little opportunity to observe his work. The loss of the mobility of the patient creates a subtle but potentially an

extremely important change in the practice environment and may upset the delicate balance of factors that maintain standards and quality.

The institutionally owned closed panel has a third disturbing aspect and that is the potential obfuscation of professional and ethical responsibility. The generally accepted modus operandi throughout Canada is that the dentist accepts responsibility for patients under his care. With the traditional fusion in one person of ownership, clinical skills and professional responsibility, the patient is assured of a clear identification of the person responsible for his care, as indeed are those responsible for the professional judicial and disciplinary functions. For example, if a patient is infected because of a lack of sterile conditions, then in a traditional practice, the dentist is responsible, but when the ownership and the provision of staff and facilities lies with an institution, this type of responsibility becomes defused. This has serious implications for the administration of the profession because it means that when non-dentists or non-licensed dental personnel play a responsible, managerial and independent decision-making role in the provision of services, these people are beyond the reach of the disciplinary bodies of the Colleges and Associations.

In this context it is important to remember that the professions were designated as self-regulating and self-disciplining bodies because the clients or patients of a profession are typically unable to judge either their needs or the quality of the service they receive. Traditionally, there has also been resistance to non-professional ownership of professional practices because lay managers, like lay patients, are not equipped to understand professional needs or requirements.

There is, therefore, something disturbing about a structure in which an employed professional is subject to management by non-professionals in the rendering of a service to a patient or to a third party. There is a potential conflict between the needs of the institution to control costs and its function of providing professional services. In the traditional private practice the "trade offs" between the level of service and cost control are issues decided by the professional who ultimately faces disciplinary action by his peers if he errs. In the institutionally owned environment non-professional managers may be responsible for these cost control decisions through the budget setting process. Such managers, as mentioned earlier, are beyond the reach of disciplinary tribunals.

The fourth, and one of the greatest concerns over the institutionally owned closed panel is that the insurer is the direct provider. This places the patient in serious jeopardy. If funding is inadequate, the administration is in a position to enforce or attempt to enforce a general regime of undertreatment to control costs. Undertreatment is possible within the profession because the patient, as stressed earlier, is not able to properly assess his own needs. Under the traditional third party insurance schemes, patient and dentist could independently and without direct pressure from the insurer assess the requirements of the patient. Currently, the potential for over or excessive treatment is addressed through co-payment and in some cases by monitoring the "profile" of individual dentists' practices.

Within an institutionally owned closed panel, the dentist is clearly in danger of being co-opted into providing less than adequate treatment as

a cost control measure without the patients being aware that they are being undertreated.

This could happen with the passive consent of dentists and dental auxiliaries merely because the manpower available is inadequate to properly treat the mandated patient pool. Under these conditions a conscientious dentist may attempt "to do the best he can" and this may mean that treatment programs are left incomplete. Perhaps more sinister is the possibility that clinical dentists are "advised" with respect to the procedures that may be done in the interests of cost control.

Part of the history of third party dental insurance has been the running battle between dentists and insurers over the "need" for some "more expensive" procedures. There is a solid body of opinion in the profession that feels that insurers are only interested in costs and do not appreciate the clinical needs of some patients. When the insurer and provider are one and the same institution, the danger exists that the patient may not get the procedures that would best serve him - for example he may get an amalgam when he should have been told he would be better off with a crown.

From the patient's perspective the institutionally owned closed panel has many drawbacks - so many in fact that it is not clear why patients would opt for such an alternative. There are two reasons why patients may be attracted to these schemes.

- 1) the promise of lower costs and more extensive service
- 2) mistrust of the private practice dentist

As argued earlier there is little doubt that insurers and patients believe that dentistry is too expensive and that costs could be cut. This belief is open to serious question and in many cases may be dispelled by a frank discussion of the economics of a dental practice. In most practices, the expenses of the practice are approximately 60 to 65% of the gross revenues; the remaining 35 to 40 percent is the dentist's income.

It is illustrative to consider just what potential there may be for cutting fees. In the following table, Case A models a typical dental practice with a gross of \$100, expenses of \$60 and a net income of \$40 (dentist's salary).

Case	A	B	C
Expense	\$ 60	60	66
Net (Salary)	\$ 40	30	33
	—	—	—
Gross (fees)	\$ 100	90	99

Case B represents a situation in which fees are lowered by reducing the dentist's salary or income. The indexed reduction from \$40 to \$30 represents a 25% decrease in the dentist's income, but because expenses are assumed to remain constant, fees (gross revenues) could only be reduced from \$100 to \$90, or by 10%.

The transition from a conventional fee-for-service practice is likely to be accompanied by changes in productivity. There is evidence that dentists on salary are not as "productive" as dentists on fee-for-service or dentists who own their own practices. Moreover, young entrants into the profession are less productive than their more senior

colleagues. A relatively modest estimate of the productivity differences would be to suppose that the salaried dentist would be 10% less productive or, put the other way around the size of the practice would have to expand by about 10% to handle the same volume of patients. Just this is assumed in Case C and here it is seen that to account for the productivity loss, the 25% reduction in dentists' salaries now is capable of generating a mere 1% reduction in total costs.

The story may appear to end here but it does not. If the institutional owner is a commercial corporation or institution that hopes to generate income from the operation of a clinic, no allowance for a return on investment has been made. Under current tax laws, the earnings or a return on investment are treated as earned income by the dentist; in Case A the return on the investment would be included in the \$40 net income of the dentist. If a commercial corporation hoped to earn a fair market return the dentists income would have to be reduced by in excess of 25%, in order for the investor to receive a return on capital.

Severe reductions in earnings by dentists raise serious concerns about the type of person who will be attracted into dentistry in the long run. Suffice it to say that potential professional caliber students will respond to economic incentives or disincentives to enter or to avoid a particular discipline. If the personal financial rewards from dentistry are low, the quality of those entering the profession will fall.

ii) THE CONTRACTED PRIVATE PRACTICE CLOSED PANEL

The contracted private practice closed panel is a variation of the institutionally owned closed panel. Superficially it would appear to avoid some of the pitfalls of the former. Under this approach the institution - union, corporation or insurer - contracts with a private practice or possibly a number of private practices for the treatment of an identified patient pool. Depending upon the nature of the contract there may be a wide variety of arrangements under these schemes with, of course, varying degrees of surrendering of professional autonomy.

The motivation for the parties to enter into an agreement or contract seem obvious. The insurer is hoping to have greater cost control either through a reduction in fees, agreed upon limitation on the frequency of some procedures, or through innovative modalities of payment such as capitation. For the insurer the contractual arrangement permits a reduction in costs and a shifting of risk to the dental practice.

From the point of view of the contracting practice the assurance of a captured patient pool is the inducement to enter into an agreement. Implicitly under the contract the dental practice will assume some of the financial risk normally borne by the insurer in exchange for a reduction in the market risk arising from the uncertainty of patient flow.

Viewed from the context of the contracting parties - the dentist and the insurer - this contractual arrangement may be beneficial to both because there may be a net reduction in overall risk for the parties. Viewed from the point of view of the profession rather than the individual

contracting dentist the problem is somewhat different. The contractor will have shifted the insurer's financial risk to the profession. The market risk to the dentist who is not a party to the contract will have increased because of the reduction in the number of available patients, those now captured to the closed panel. This could create an obvious problem in some rural areas of small towns.

It is quite natural that insuring institutions wish to control costs and reduce their risk exposure; the appropriate question, however, is whether it is in the interests of the patient that insurers should be permitted to do so or whether such arrangements expose the patient to some risks. Unfortunately, it does appear that contractual arrangements could put the patient at risk - the risk of under treatment or deficient treatment. This may arise because the contract obscures the roles of insurer and provider of service. The contract places the dentist, to some extent, in the role of the insurer. Earlier we discussed the jeopardy in which the patient may be placed if the roles of insurer and provider are fused. The dangers noted earlier are inherent in the contract.

The attraction of the contracted private practice closed panel is that it may provide some protection against the possibility of over-servicing of the patients. Just how the individual practice responds will depend upon the circumstances of the individual practice and the conditions of the contract.

Assuming for the moment that the contract provides for a fee-for-service at a rate less than that normally charged by the practice, the practice could still "over service" if it was not busy enough to utilize all of

its capacity. It may under service if it is so busy that it can replace patients at discounted fees with patients who are paying the "full fee". The discounted fee creates an economic incentive to discriminate against the patient who is captured by the closed panel. The closed panel aspect of the contract clearly makes this a greater likelihood and the implied cost control makes it an agreeable outcome from the insurers point of view. There is little evidence to suggest just how the profession would respond over time to a discriminatory fee structure or how the long term welfare of the patient may be affected. Clearly, however, the apparent attraction - from the patient's point of view-is the possibility of a reduced cost of care, but this also creates the possibility that he may be discriminated against.

iii) THE OPEN CONTRACT FREEDOM OF CHOICE ALTERNATIVE

The next generically distinct alternative is the situation in which the patient is free to chose any dental practice which has "contracted" with an insurer to provide a service. Thus, any dentist who found the terms of a contract acceptable could become part of the panel. Such contracts may typically secure an agreement from the dentist to charge only a prescribed level of fees or to agree to the conditions of a capitation scheme.

From the perspective of the patient this is a more attractive approach than those discussed earlier. The patient may come to understand the real restrictions that are placed on his care if many dentists, or the dentist of his choice, refuse to become subscribers to the plan. A massive refusal to participate in such a plan could be generated either

by restrictions placed on the nature of the procedures to be performed, the overall level of care (frequency of procedures), or the implicit fees. If large numbers of dentists find the plan acceptable, the patient may have some reassurance that his choice of plan meets with a degree of professional approval.

The fact that the profession will pass judgement upon the plan would probably have some effect upon those designing the plan and lead them to make more professionally acceptable trade-offs between cost controls and quality of care. Conversely, large plans that may affect a large number of patients may have real market power and be able to constrain fee increases or to impose clinically undesirable restrictions on treatment. In this respect, it is important to recognize that existing plans may promote this type of restraint in those jurisdictions where private fees are high and dentists elect not to charge the co-payment factor for fear of losing patients.

It may be expected that if such open contract plans become popular the profession would respond by attempting to negotiate the content of the contracts. Many observers may consider this an improvement over the current situation in which market power is alleged to reside with the profession. Whatever market power the profession has, is being rapidly eroded, however, by the expanding number of dentists and trained auxiliaries. Even now, patients may not need the countervailing power of an insurer to counteract the dwindling market power of the dentist.

It is difficult a priori to determine what affect open contract plans may have upon under or overservicing of the patient and hence on some aspects of cost control. The outcome with respect to this issue would

appear to depend heavily upon the specifics of the contract and, for example, the amount of co-payment.

It is extremely difficult to assess open central plans on a general basis. The existing third party fee-for-service plans are implicitly an open contract plan when the dentist accepts reimbursement from the plan. The absence of a "written contract" in these cases has still permitted dentists and patients to freely assess the patient's needs and have allowed the dentist to perform services outside the plan.

The evolution of more formal, written open contract plans could very well place limitations on the profession and put the patient at risk. If such plans become important, individual dentists may for economic reasons agree to accept a contract even though he disagrees with the conditions of the plan; he may do this on the simple logic that if he does not accept the plan the dentist down the street will. In this case the patient may be left with the erroneous impression that, for example, restrictions on procedures, are acceptable to the dentist.

A further change in these schemes, is that the patient may not know, or understand the nature of the contract between his dentist and his insurer and this could leave the patient without any recourse to a truly independent professional assessment of his needs. For example, if there are fixed revenues or revenue limitations on the treatment of a patient, it may be to the financial interest of both the dentist and the insurer to implicitly conspire to undertreat the patient. Clearly this is undesirable.

Lastly, it should be observed that open contract plans, like all the preceding plans have an administrator interposed between the dentist and the patient, for whom the patient must pay. Thus, as such plans cease to be "insurance" programs and become, in effect mere prepayment programs, they will survive only as long as the administrative agent is able to get reductions in fees in excess of the cost of the administrative services. In fact, in various ways the previously discussed programs also depend upon this cost reduction for their success.

At this juncture it is appropriate to consider whether or not administration of open contract plans can expect long term success or whether their success is likely to be transitory. We believe, at best, that it will be transitory for two reasons:

First, success depends upon dental fees generally being excessive and there being some long term reasons why they continue to be excessive. If fees are close to the costs of production, then it will not be possible to persuade individual dentists to accept a reduction. Rather than do this it would be rational for them to leave dentistry and pursue some other careers. The expanding manpower problems have put considerable pressure on dentists' incomes. If manpower continues to expand at the rates currently forecast the out-migration of dentists from the profession to financially more attractive careers may begin in the next few years. In fact, it may have begun in a limited and disguised way already.

Secondly, the success of the open contract plan depends upon there being no competitive reaction to the success of the plans themselves. This

seems most unlikely. Dentists appear to be keenly aware of the fact that they are in competition with one another. If reduced rates become accepted for members of open plans it will be a simple step for dentists to make such rates available to all patients. Once this happens, the *raison d'etre* for such plans is sorely compromised.

If open contract plans were few in number and of minor significance, they may have a reasonable prospect of long term success. It is difficult to visualize circumstances in which a few plans were successful but in which they fail to expand in number or size.

The last problem posed by open contract plans is one of assessing the contract. Many dentists may be unaware of the potential implication of some forms of contract, for example, those involving capitation. Fear that they do not understand the content of a contract may involve legal costs for an opinion on the dentists obligation under the contract or costs to defend oneself against a failure to properly discharge one's responsibilities. These expenses would benefit neither the dentist nor the patient.

While open contract plans may be less objectionable than closed panel plans, they are not without objection. Many of these objections arise from the likelihood that neither the dentist or the patient full understands the content of the contract and that professional care is compromised by the contract. The very concept of the open contract, must draw attention to the fact that a third party is attempting to "sell" a concept of dental care to the patient and that neither the patient or the third party may be professionally qualified to assess the merits of the concept. The question must be asked whether there is a

role in the delivery of a professional service of an insurer to make a contractual condition on how a dentist should deliver or how a patient should receive care. When the answer to this question is sought it must be remembered that not all proposals for alternative delivery systems are based upon altruism.

IV DIRECT REIMBURSEMENT PLANS

In the face of prospective changes in the delivery of dentistry in the U.S.A., various groups and individuals have advocated the creation and expansion of Direct Reimbursement Plans. Under such plans the patient goes to the dentist of his choice, pays his bill to the dentist and then present his bill to the source of his benefit - his company or union and is reimbursed in whole or part for his expense. Advocacy of such approaches rests on the elimination of the cost of a separate plan administration. Such plans might more descriptively be called self administered, self insurance plans. From the perspective of the traditional dental practice such plans appear to be very attractive because they do not interfere with the traditional patient - dentist relationship. Clearly, however, direct reimbursement plans fail to address the major problems that may concern the patient and which were discussed earlier. In short they appear to do little to control costs because there are no contractually imposed conditions on the dentist.

Direct reimbursement plans may be deceptively simple and capable of achieving much more than the absence of contractually imposed conditions would suggest. There is some evidence that direct reimbursement creates

a climate in which the patient assumes some responsibility for cost control. This means that some of the alleged abuses of current third party dental plans are avoided.

Clearly, however, if direct reimbursement plans pay the same fees that private patients do, the greatest benefit arising from them is tax avoidance. Such plans might collapse rather rapidly if the tax advantage were removed.

v) MODALITIES OF TREATMENT: FEE-FOR-SERVICE, CAPITATION AND SALARIES

Various contractual arrangements for the delivery of service can be paired with different forms of payment to the dental practice. As is evident from the earlier discussion various "structural" arrangements are objectionable from the point of view of the patient and the dentist, and in the interest of the patient's welfare should be discouraged or avoided. Some of the specific contractual or institutional settings for dentistry more naturally lend themselves to some particular forms of payment rather than others, but, with a little imagination, it may be seen that most institutional or structural arrangements can be coupled with most forms of payment.

A company-employed dentist could work on salary, fee for service or capitation, or on a mix of these payment schemes. Contracts with private practices could be written to include fee-for-service, capitation or hourly (salary) forms of payment.

Because the combination of structural delivery systems and payment schemes is nearly limitless, it is useful to attempt to separate the

institutional structure from the method of payment and address the form of payment as a distinct issue.

For dentists the modality of payment is clearly an emotional issue. Objectivity and a reasoned response to the patient's needs are not easily achieved but if dentists are to be successful in the debate over various forms of delivery, objectivity is essential.

For many observers outside the health care profession, fee-for-service has many objectionable features. Fee-for-service may create inappropriate incentives and may be the direct cause of abuse. The arguments against fee-for-service are extensively discussed in the literature on the economics of medicine and dentistry and only the major points need to be mentioned here. Fee-for-service may create the following problems:

- overtreatment
- expensive services substituted for clinically satisfactory cheaper services
- the provision of restorative services rather than preventive services
- billing for services not performed
- discrimination in terms of fees charged
- patient uncertainty about total cost of treatment
- neglect of the quality of treatment

There is little documentation on the existence or the severity of any of these problems. It is facile, however, to suppose that documentation is lacking because these problems do not exist; it is, rather, that adequate research has not been done.

In spite of the disturbing list of criticisms that may be leveled at fee-for-service, the dental literature has used fee-for-service as a yard stick for the comparison of other modalities of payment schemes. This is particularly true of criticism from within the profession of capitation proposals. However many researchers have pointed out that capitation could generate some special problems of its own. These include:

- undertreatment
- recourse to an inexpensive procedure when a more expensive one is called for
- delaying of treatment
- discouraging patient utilization
- attempts by G.P's to perform procedures that may be better performed by specialists

A number of other concerns may be added to this list but one which appears regularly in the dental literature is the suggestion that capitation represents an assault on the "democratic principle of freedom of choice": This is a curious and dangerous concept and must be closely examined before it becomes part of the profession's armament against capitation.

The notion that capitation limits freedom of choice shows a lack of understanding of the history of the labour movement and the law of contract. Historically unions have fought for programs that cover all their members. Pension benefits, deduction of union dues, insurance benefits, restriction on work to be performed by members and a host of other things negotiated by unions with their employees may be said to restrict the right of the individual. Typically, union members do not

see this as an infringement of their rights. Rather their democratic rights are exercised by their right to elect union officials and to participate in the formulation of union policy. If elected union officials negotiate a dental plan based on capitation, they are answerable to the membership. If the individual member violently disagrees with the majority he is not forced to participate in the plan and ultimately he has the freedom to leave the union. However, it should be remembered that he might do this because he does not like paying union dues, the pregnancy benefits or any other things that are collectively done. It must be remembered that unions work for the "collective good" and that whatever outsiders may think about collective action it is sanctioned by law and supported by union members.

The argument that capitation threatens freedom of choice is dangerous because it is so easily reversed. Efforts on the part of organized dentistry to "outlaw" capitation agreements would be regarded by many as an attempt by dentists to restrict the freedom of responsible parties - dentists and organized groups - to enter into their choice of contract. The question which is not extensively dealt with in the existing literature and which must be, is this: if a properly informed dentist or group of dentists and an organized group wish to enter into a capitation agreement why should they not be permitted to do so? The answer must lie in the fact that it poses a potential health hazard to the patient.

Most contracts contain a potential risk to the parties that enter into them so the fact that the parties to a capitation agreement expose themselves to a variety of risks is not sufficient reason for outlawing

capitation. What organized dentistry may not like is that capitation throws increased risk on the shoulders of the dentist, but what the profession must recognize is that capitation counteracts some of the disadvantages of the fee-for-service model. A blanket prohibition against capitation would undoubtedly drive some groups to become direct providers and to eschew private practice.

What may have happened in the literature is that capitation as a concept has been confused with closed panel capitation and the criticisms that are justly leveled at the closed panel have lead to the condemnation of capitation. Capitation schemes are, of course, compatible with freedom of choice. The provider of a benefit may provide each beneficiary with a capitation contract and the patient then finds a dentist of his choice who will agree to the contract. The provider of the benefit would, upon return of the contract, make the capitation payments to the dentist.

If patients found that dentists refused to accept the contract they would know that the conditions were not acceptable to the profession and that improvements would have to be made in the contract. It is also possible that under a master agreement the patient and dentist could make further agreements - for example for increased compensation or fees for some other types of services.

Lastly, one must consider the political ramifications of opposing capitation. How will such opposition be viewed by governments and how would opposition to capitation affect the case against alternative delivery schemes?

Unfortunately, it doesn't appear to be possible to document the inferiority of capitation when compared to fee-for-service. For

arguments against capitation there are arguments against fee-for-service. One bit of anecdotal evidence will simply call forth the counter example. Opposition against capitation per se will appear to be self serving. It should not be a cornerstone of the opposition against some aspects of the emerging alternatives to the traditional private practice.

This does not mean that opposition to capitation is unfounded. As indicated earlier, capitation generates its own list of deficiencies and drawbacks.

Throughout the analysis of the emerging alternative delivery system it was found that the welfare of the patient is jeopardized by the risk bearing insurer providing direct delivery of service or by the dentist being subservient to a contract which may compromise the professional assessment of the patient's needs. Unfortunately, capitation exposes the patient to both these risks.

Part III

RESPONSES TO ALTERNATIVE PRACTICE MODES

Response to the undesirable characteristics of some of the alternative practice modes must take two forms. One is an attack upon the basic problems that have lead to interest in alternative delivery systems and the second is an attack upon the undesirable characteristics of some institutional structures. The latter of these issues must be addressed through legislation; the former may largely be addressed internally by the profession. Successful opposition is going to be difficult and it may take several years to achieve. There appear to be no quick fixes. We turn now to the basic causes.

i) EXCESS MANPOWER

The first two items on the list of contemporary problems that have given rise to interest in private sector alternatives were an excess supply of dentists and auxiliaries. The fuel - manpower - for alternative delivery schemes would be cut off if the manpower problems could be brought under control. This, however, is a long term and not an immediate solution. The only short term measures appear to be the use of an externship which may be restricted to a traditional private practice. This could have three immediate salutary effects:

- i) reduce the supply of cheap manpower to entrepreneurs
- ii) immerse the new graduate in the ethos of the private practice
- iii) encourage the development of associateships and circumvent the problem of the high capital costs faced by the new graduate

Details of externships would have to be worked out between the dental schools and the provincial colleges and associations. C.D.A. could play a valuable leadership role in initiating immediate consideration of the benefits of externships which, of course, extend beyond the issues considered here. The reason why an institutionally owned practice should not be permitted to hire externs must be carefully framed.

The increased manpower has meant that bargaining power has now shifted to the entrepreneur and away from the dentist, particularly the young dentist. This is a situation that could be redressed by effectively organizing salaried dentists or those working on a commission basis. The provincial Colleges and Associations are accustomed to publishing fee guides and this activity could be extended to the publishing of fair wage guides, and taking an active role in representing salaried or commissioned dentists.

The logical, albeit controversial, step would be the creation of a professional association of salaried dentists (and auxiliaries?) with the power to strike against institutional employers. This is a proposal that must be looked at very carefully because of its wide possible repercussions.

ii) HIGH CAPITAL COSTS

The third reason, which predisposes new graduates to consider employment by alternative delivery systems, is the high capital costs of entering practice. Use of externship helps to address this problem but direct support could be provided through the provincial Colleges and Associations which may wish to consider providing further advice on

setting up a practice, underwriting bank loans and so forth. This would represent an expanded role for the Colleges and Associations and as such would be controversial. It would not appear to be a very promising avenue.

There has been some suggestion that some institutions may be granted substantial discounts on equipment and supplies that are not available to private practice dentists. C.D.A. may wish to further investigate these suggestions and if appropriate, raise the issue of discriminatory policies with those companies that appear to be prepared to engage in such policies.

iii) ADVERTISING AND MARKETING

The visibility of retail chains and their national coverage would appear to give them an advantage in marketing themselves. Perhaps thought should be given to whether the current restrictions placed upon the individual dentist should be liberalized in order to redress the imbalance.

Clearly, this is a matter that must be addressed at the provincial level but since some firms or institutions may be national in scope and therefore be marketing on a national basis, it is an area in which C.D.A. leadership may be very effective.

iv) PERCEPTION OF THE COSTS OF DENTISTRY

While a considerable amount is known about the earnings of dentists in private practice virtually nothing is known about the profitability of

franchise operations or the costs of some of the existing alternative systems. There are a priori reasons to suppose that some alternative delivery systems, in fact, are not particularly profitable.

Clearly, one of the most persuasive reasons for not becoming involved in alternative delivery schemes would be their apparent unprofitability. It would be invaluable to attempt to obtain, perhaps by means of a special CDA survey, some relevant statistics on these alternative delivery systems. If relevant information could be collected it would be appropriate to publish it in the CDA Journal and to disseminate it to the provincial colleges and associations.

In considering the most appropriate strategy some thought should be given to the idea of inviting the Chief Executive Officers of various dental plans to a closed panel discussion of the past, present and future of alternative delivery systems. The committee members may learn a considerable amount about the current operations and future prospects of alternative delivery schemes if such a conference is properly structured. Moreover, for future political reasons, arguments to government may be more credible if C.D.A. can point, with dissatisfaction, to a dialogue with representatives of the various plans. Until a coherent policy is developed, it is important to maintain a "friendly" contact with those developing alternative delivery systems.

In an attempt to secure the release of financial statistics, it may be desirable to study the question of whether - perhaps through the superintendent of insurance - all participants in a capitation program could be required to make public their financial statements. This would

enable any group or individual interested in contracting with a dentist on alternative delivery systems to assess the financial strength of the practice and its ongoing ability to render service. It may be expected that many groups and individuals would shy away from public disclosure of their financial status.

The public perception that dentistry is expensive is a notion that can be challenged in the media. The real costs of dental services have declined over the past twenty years and have declined dramatically for those that practice good home care and successfully reduce caries. Grass root interest in alternative delivery systems may be curtailed if it can be successfully argued that the savings to be realized by "having a plan" may be small. The public may well think that dentistry is too expensive but with few exceptions the public appears to think most things are "too expensive".

C.D.A. may wish to consider the development of a pamphlet that could be placed in dentists' offices that would pose the question "Do you need a dental plan?" in which the costs of care are compared with premium costs. One has the impression that some dental health conscious individuals may be financially worse off with dental benefits than they would be if they received an equivalent amount in other benefits. Such information may generate an informed discussion with union and employer groups about the need for dental insurance, and hence alternative delivery systems.

The major advantage of belonging to a plan is that it allows dentistry to be paid for with pre-tax dollars. C.D.A. has, of course, actively lobbied for the continued tax exemption of dental plans but this is a

policy that must be carefully considered, because the favourable tax treatment of dental plans is a stimulus to alternative delivery systems. There can be no doubt that dental insurance has contributed to the growth of the demand for dentistry and has increased utilization rates but it is possible that improved utilization through dental insurance is no longer likely. It is also likely that if insurance programs were discontinued utilization rates would not fall significantly. In other words, once the habit of regular treatment is established patients will maintain regular care with or without an insurance program. Some evidence for this can be found in the withdrawal of the B. C. Dental Plan.

v) THE POTENTIAL COLLAPSE OF DENTAL INSURANCE SCHEMES

The forces that determine the long run fate of third party dental insurance schemes may be beyond the control of the dental profession. In fact, to the extent that "dental insurance" spawns an interest in alternative delivery systems, there is a sense in which the demise of third party insurance may be welcomed. The justified fear of the collapse of third party insurance is that the demand for dentistry would decline and, because of the manpower problem, lead to further decline in busyness. This fear would likely vanish, if some alternative to third party insurance could be developed which would maintain utilization rates. The profession should be considering what alternatives are available and how effective they may be in encouraging effective demand for services.

Direct reimbursement plans have met with some success in the United States and, as long as the tax advantage remains in effect, they would

appear to be a promising avenue in Canada. What is needed is the dissemination of information on direct reimbursement plans to those groups that are considering dropping third party insurance.

The real problem is to determine who needs the information. A basic requirement would appear to be a registry of dental plans so that the profession would know who to contact. C.D.A. may wish to take the initiative in developing such a registry and informing those who are responsible that C.D.A. has available material on direct reimbursement plans as an alternative to third party insurance.

This obviously would require the preparation of an appropriate information kit.

A second distinct approach is the direct stimulation of demand through public awareness programs, a need that C.D.A. has already anticipated.

Lastly, C.D.A. may wish to consider maintaining pressure on Revenue Canada to make all dental expenditures fully tax deductible.

vi) FEARS OF ABUSE, OVERTREATMENT, OVERCHARGING AND DUAL FEE SCHEDULES

Allaying public fears about abuse at the hands of the private practitioner will not be easy. These fears are deeply rooted and will not be dispelled by appealing to the facts and pointing out that if abuses do occur they are the exception rather than the rule. However, in an atmosphere in which it is presumed by the public that abuse does take place it is important that the profession does an effective job of policing itself. This is a touchy subject which must be dealt with at the provincial level.

The profession should not allow itself to be put in a defensive position in which it is implicitly answering allegations of abuse. Rather, it may be more effective to expand the information kit that may be made available to union and management groups and point out the positive aspects of dental health in Canada. Namely, that it has never been better and continues to get better, and that it has never been cheaper and it continues, in real terms, to get cheaper. This positive information approach could be reinforced with a discussion of the abuses that may occur under alternative delivery systems.

PROPOSED TERMS OF REFERENCE

SUB-COMMITTEE ALTERNATE DELIVERY & PAYMENT SYSTEMS

1. To develop expertise on the wide variety of Alternate Delivery and Payment Systems developing in North America.
2. To develop educational material for articles on these alternatives to be circulated to the profession.
3. To assist each of the provincial corporate bodies to develop a Committee and assist this Committee in developing local expertise.
4. To recommend to the Board of Governors via the Third Party Committee action to be taken regarding Alternate Delivery and Payment Systems.
5. To identify factors that provide the environment for Alternate Delivery and Payment Systems.

CDA Third Party Dental Plans Committee
January 1986

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Council Members: Dr. R.Y. Barolet, Chairman, Quebec
 Dr. W.B. Chapple, Ontario
 Dr. G. Nikiforuk, Ontario
 Dr. J. Speck, Ontario
 Dr. W.C. Sturtridge, Ontario

Observer: Dr. T. Dubas, Health Protection Branch, Health & Welfare Canada

1. Committee Meetings

The committee has met twice since the last report to the Annual Board - on October 28, 1985 and via a telephone conference call on January 8, 1986.

Items For Information - Not Requiring Board Action

2. Crest Tartar Control Toothpaste

An application was reviewed from Procter & Gamble for their new Crest Tartar Control Toothpaste. Much of the discussion was held on whether this product had a therapeutic benefit or whether the benefit was merely cosmetic. Health Protection Branch indicated that Procter & Gamble would have the product approved based on a cosmetic claim only. The committee resolved that the Crest Tartar Control Toothpaste be approved as an effective anti-caries agent due to its therapeutic content and that it should receive the Canadian Dental Association's Seal of Recognition. The committee will monitor advertising on this product to ensure that the first thrust of the advertising will be the anti-caries benefit and the cosmetic claim will be secondary. Any reduction of supra gingival calculus will be promoted on a cosmetic basis only because the formula's impact on gingival and/or periodontal disease has not been determined.

3. Gibbs & Mentadent Toothbrush Advertising

Lever Detergents have published an ad for the above toothbrushes and in the ad copy they say that the CDA has approved a particular toothbrush design. After consultation with the lawyers the committee felt that this action taken by Lever Detergents was unacceptable and they have been asked to withdraw their statement.

4. Update Anti-Plaque Guidelines

The American Dental Association has recently approved a set of guidelines for plaque removal as this applies to dentifrices. The chairman was invited to attend the last meeting of the Council on Dental Therapeutics of the ADA and at that time a copy of the new anti-plaque guidelines were received. These guidelines will be considered at the next meeting of the committee to determine whether or not they should be modified for use by the committee.

5. Colgate Anti-Tartar Dentifrice

A submission has been received from Colgate-Palmolive to consider the Anti-Tartar Formula of Colgate's dentifrice. The committee reviewed the documentation and essentially approved the awarding of the Seal of Recognition to Colgate again on the basis of the therapeutic anti-caries claim only. As in the case of Procter & Gamble, the advertising will be closely monitored to ensure that the therapeutic claim of anti-caries will be prominently featured and that the tartar control will only be a cosmetic claim.

6. Advertising Review

Advertising will continue to be monitored from all of the companies as has been done in the past. However, in the past only the English copy was reviewed and the French copy was not. From now on the English will continue to be monitored by the past chairman, Dr. Chapple, and the French copy will be reviewed by the Chairman.

7. Chairman

On November 29, 1985, Dr. Ralph Barolet was appointed chairman of the committee replacing Dr. Brad Chapple. The committee members are very grateful to the work that Dr. Chapple has done in the past and look forward to his continued interest and advice at future committee meetings.

Respectfully submitted

Ralph Y. Barolet, DDS, MSD,
Chairman
Consumer Products Recognition

ADOPTION OF REPORT

The Board of Governors receives the report of the Committee for Consumer Products Recognition with appreciation.

GOVERNMENT RELATIONS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. Ron J. Markey, British Columbia, Chairman
Dr. John R. Robertson, Prince Edward Island
Dr. Bradley W. Holmes, Ontario
Dr. Robert N. Hicks, British Columbia
Dr. P. Ralph Crawford, Manitoba

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTIONINTRODUCTION

It is essential at this time that the CDA Government Relations initiative be put in perspective. By this, it is meant that the goals, objectives, duties and responsibilities and program must be organized and explained in a manner that is consistent with the CDA's ability to utilize existing human and financial resources to achieve its aims. The short term goals should still not lose sight of the original long term plan.

I would like to approach this report in five (5) segments.

1. A synopsis of the activity outline for the Government Relations program. This will be presented as an abbreviated and concise working document.
2. A review of the perceived problems of CDA, and some solutions that have been initiated.
3. A specific plan of action concerning several areas, including some suggestions regarding existing activities and an activity outline for the balance of 1986.
4. A summary of on-going activities.
5. Extract from the Taxation Report appended.

PART I - SYNOPSIS OF GOVERNMENT RELATIONS ACTIVITY OUTLINE

A - ASSUMPTIONS

In deciding to mount a Government Relations Program, Executive Council declared a set of assumptions which would serve as its underpinning:

1. that the CDA would adopt a socially responsible approach in its relations with government;
2. that the CDA would adopt a collaborative, cooperative, client-based approach in its government relations program;
3. that the CDA would take a long range planning horizon (5-10 years) in developing and implementing a sound government relations program;
4. that the time is particularly opportune for such a program, in that the federal public service is receptive to new CDA initiatives; and,
5. that the CDA would solicit and seriously contemplate input from all qualified sources, within and outside dentistry.

B - GOVERNMENT RELATIONS COMMITTEE

With these assumptions, the Government Relations Committee was established, with a set structure and a framework of Duties and Responsibilities. Following is a brief outline of these two elements:

1. Structure

The Committee is composed of up to six voting members, including: Management Committee, Executive Director (ex-officio), and three other members.

Reports to Executive Council.

One year renewable terms.

Chairman appointed annually by the President.

GOVERNMENT RELATIONS

2. Duties and Responsibilities

1. To act as the focal point for co-ordination of all CDA government relations activity.
2. To decide on a theme and message thrust to pursue in government interaction.
3. To ensure that the necessary timely policies are formulated on key issues requiring a formal CDA government position.
4. To appoint approved spokespersons for each policy position.
5. To provide for the establishment and maintenance of a system to effectively inform, link and monitor spokespersons for government relations activities.
6. To ensure that new GRC members and spokespersons are thoroughly briefed on committee work and government relations activities.
7. To determine, as appropriate, special government events such as meetings with ministers, chiefs of staff, and departmental program personnel.
8. To determine editorial policy of the Journal as it relates to government relations activities.

C. OBJECTIVES AND GOALS

The Objectives and Goals for the Program, to be sanctioned for implementation by the Committee, are as follows:

1. OBJECTIVES

1. to serve the dental community through government activity;
2. to operate in the public interest in assuring that all Canadians have the best possible oral health care;
3. to positively and cooperatively influence government policy with regard to oral health care;

-
4. to be recognized by government as the authoritative national voice of Canadian dentistry;
 5. to signal clearly the CDA takes its social responsibility seriously with such compromised groups as: natives, the disabled, and the elderly; and,
 6. to have and be seen as having:
 - technical competence
 - a powerful national base
 - clearly established principles
 - a collaborative posture while protecting confidentiality
 - an interest in developing stable long-term relationships
 - effective (working relationship with) other health and related professionals
 - political sophistication which comes from knowledge and understanding of government systems
 - the capacity to operate effectively in both official languages.

2. GOALS

A sampling of principal goals for the GRC, formative stage follows:

1. establish a Government Relations Committee;
2. establish a system to monitor government contacts;
3. research CDA position in Health community (30-40 interviews);
4. establish key positions and appoint spokespersons;
5. establish a joint-ownership government relations approach;
6. develop government information system;
7. establish government relations editorial policy;
8. undertake a plan of government relations events; and,
9. link Dental Awareness Program to government relations activities.

GOVERNMENT RELATIONS

PART II - REVIEW OF PERCEIVED CDA PROBLEMS

We have recently been provided with a synopsis of the interviews conducted by Bill Wilton on behalf of CDA. These interviews have elicited a wide range of comments on a number of CDA-related activities. It is interesting to take those comments which directly criticize CDA and its Government Relations activities, and analyze them from the perspective we have gained due to changes in our own structure over the past twelve months. Although this could be viewed by a cynical reader as an attempt to exonerate the CDA of all "errors and omissions", it is anything but; the fact is that the "self-analysis" that began with the Montebello Retreat had a profound influence in terms of changing our attitudes and priorities. The other major change has been the acquisition of Mr. Neilson as Executive Director of our Association. Although the process itself was disruptive and time-consuming, there is a perceptible change, clearly expressed by groups (including our own councils and committees) who do business with CDA. Let us get down to some specifics, look at some of the main "complaints" and evaluate what, if any, progress we have made to date.

1 - It has been said that:

- a) "The level of competence of CDA activities has decreased."
- b) "Government Relations are not a priority of the elected representatives or the staff of CDA."
- c) "Meetings with Government officials tend to take place on an ad-hoc basis, are always issue related, and are generally uncoordinated."
- d) "CDA information sources are often contradictory."

On the other hand, it has also been said that the Federal mood has been conciliatory, and that Federal officials have seen the trend in relations improving over the past eighteen months.

The increased emphasis on Government Relations is a priority that does indeed go back approximately eighteen months. Our success stories have been related to the area of taxation, and the positive images created in minds of many government officials by our Dental Awareness Program.

GOVERNMENT RELATIONS

Our activities are more structured in terms of developing long term working relationships with stakeholders such as Medical Services, Health Services and Promotion, and Health Protection Branches of Health and Welfare Canada, and Customs, Excise and Taxation Branches of Revenue Canada. Our Executive Director also maintains contact with officials in a number of areas on an on-going basis (examples to be detailed later in report). We are all more conscious of the quality and consistency of information, and it is my feeling that the quality of discussion taking place represents a more consistent CDA position than in the past. Our efforts in dealing with other current priority issues such as Professional Resource Utilization, Third Party problems, and Prelicensure, are examples of our attempt to achieve problem definition and solid national consensus before developing firm, well-founded CDA positions. We are clearly moving in the right direction. However, we must continue to be concerned about response time, and the need to have more people, at all levels, understand what we are trying to achieve.

2. Taxation has been perceived by many individuals as the "shining light" in an otherwise lackluster Government Relations initiative.

The reason for this is simple; it has been our most active, successful, and best-publicized venture to date. This is because the activity has seen steady development, utilizing a consistent and predictable approach. Contacts were nurtured and built, and the level of communication and trust established. The results followed, and in fact continue. Dr. Hicks deserves tremendous credit for what he has accomplished. His methodology is important, and I have asked him to elaborate on this in his Taxation Report, a portion of which is appended. We can and will achieve the same reputation in dealing with other branches and agencies of Government. The success will be based on an on-going, consistent, developmental approach, with the right "players" in place. It is also time we paid more attention to the fact that we will only be successful if we are perceived as being successful. More on this later.

3. CDA is perceived to have a poor knowledge of how the Federal Government functions, and an equally poor knowledge of provincial government systems.

Here, we are improving. It is my intention to highlight this at the Interim Board of Governors meeting in April (see Part III of this report). Mr. Neilson brings to us a thorough and in-depth knowledge of the working of the bureaucracy and government, and we are beginning to take advantage and profit from this experience. He has also begun

GOVERNMENT RELATIONS

to establish excellent rapport with provincial Executive Directors; this, I expect and believe, will improve, as he is able to meet with different provincial groups over his first full year.

Two other comments of significance are:

- a) "The visibility of the CDA Executive Director is important".
- b) "The CDA needs regular staff contact to ensure continuity".

We agree with these observations. Mr. Neilson will be an integral part of the "continuity" factor in our Government activities. From the response he has achieved to date, there should be no hesitation in increasing his visibility (minus cigar of course), and this will be done when necessary to highlight our "in house" expertise.

- 4. Our relations with Health and Welfare are perceived to be poor.

Dr. Holmes will likely elaborate on some recent meetings and decisions that will begin to change our image in this area.

- 5. Increased involvement of non-dentists is seen by some as an important thrust in our decision-making processes.

We have recognized this; the addition of lay representation to our Professional Resources Utilization Committee, as well as our support for the composition of the Health and Welfare Study Committee of national dental delivery systems to native people, is the proof. We should continue to be aware of this factor in future ventures.

- 6. Health officials are concerned about proper dental care for the poor, the elderly, the disabled and native people in communities. They want to cooperate with us in finding solutions.

We should share this concern, as there are many unsolved problems which are getting worse. Discussions have commenced with Health and Welfare Canada. We cannot jointly solve all problems over-night; but if the kind of trust we need to build is established, we can be more optimistic about meaningful dialogue on all of these related issues in the future.

7. The lack of information on the reasoning behind executive decisions has reduced the effectiveness of committees (or councils) in certain instances, as well as stifling initiative and enthusiasm.

We have recognized this and hopefully have devised a system that will work more effectively.

8. It has been suggested that we increase the technical calibre of committee appointments.

This has been recognized. Our council and/or committee system is still under review by our Roles and Responsibilities Committee. As an example, Health Care has modified its working structure and recognized the necessity of having reports written by people with subject expertise, whether or not they are members of Council. We should encourage provincial groups to send us the highest calibre of individual possible, and we should not hesitate to request specific expertise where necessary.

9. Our response time to issues is too long.

This problem will never be completely resolved in a national organization. We have attempted to deal with it, and when our review of Roles and Responsibilities is completed, we will be able to move forward more quickly. The Executive wants to move expeditiously when an issue demands. We must continue to find more effective ways to solve problems, and be more prompt in promoting the solutions we develop. As an example, Health Care has streamlined its operation, and appears to be working more effectively. The Third Party Committee has done a remarkable job in a very short time, in establishing itself nationally. It is a small group that is moving quickly in several important areas, and represents the type of structure that seems capable of minimizing the response time on important issues.

10. "In house" problems were identified by quite a few people. These included:

- a) "Telephone calls not answered"
- b) "Letters unanswered"

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Our Executive Director has implemented a current policy whereby it is the norm for telephone calls to be returned the same day, and letters to at least be acknowledged within forty-eight (48) hours of receipt.

11. We score poorly in the area of participation as a national health organization, in matters relevant to the general health community outside of dentistry.

This is a valid comment. However, our support of the CMA in its bid to clarify the Canada Health Act, and our decision to take a stand on the smoking issue, are departures from this trend. Also, our Awareness Campaign is a more tangible effort to communicate our concern for Oral Health to both the public, and officials of government. We must continue to accelerate our level of involvement with our colleagues in other professional disciplines. This offers obvious advantages when we pool our talents to pursue items such as pension reform, and third world health issues. This will continue. There is also much to be learned from other groups; it is our intention to meet with officials of CMA, as part of this year's activities.

12. The Journal could be more useful in explaining CDA initiatives in Government relations.

The Editorial Board of the Journal is currently taking a close look at its format and its future. There is no question that we do not take maximum advantage of the Journal as a medium for communicating political messages. It is one thing to make improvements in our method of operation at the political level, and another to communicate the nature of our activities on a regular basis. The Journal and the Communiqué have been effective, but in general, it is still safe to say that a lot of good things done by CDA go unnoticed. We must find ways to improve communications with our publics.

PART III - SPECIFIC ACTION PLAN FOR 1986

The following are suggestions that should be discussed at the committee and the Executive level:

a) Taxation:

It is recommend that this area continue to function as an identifiable committee under the umbrella of the Government Relations Committee. In order to ensure continuity, it is suggested that Mr. Neilson act in concert with Dr. Hicks, whenever possible, at meetings or conferences organized by either. Dr. Hicks is willing to accept direction from the Executive, and if we wish, would accept any nominee of our choice to assist him. It is my feeling that such an addition would not increase our effectiveness or aid in continuity any more than if the above suggestion were followed. In fact, an addition would increase committee expenses, and would result in more meetings than are necessary, since at this time, a great deal of committee work is done by telephone. We should aim to make all our committees and councils leaner and more efficient. Expansion in this area, at this time, is contra-indicated.

- b) The Interim Meeting of the Board of Governors in April should be used to highlight some of our in-house expertise. It is suggested that the Government Relations Report be succinctly presented, (based on all the enclosed material), followed by a presentation by Mr. Neilson. His subject should deal with taking a CDA problem through the different levels of bureaucracy, in order to achieve a solution. In short, a presentation on how to deal with the Federal bureaucracy.

If we are to combat the image of CDA as an organization which doesn't really know how to deal with Government, what better way than to have our Executive Director begin to communicate the fact that some things have changed. It is essential that all groups understand why we have a right to feel more confident about our future.

GOVERNMENT RELATIONS

- c) The Government Relations Committee should function as structured for at least two to three years. It should then be thoroughly reviewed, with consideration given to at least part of the committee make-up reverting to non-executive personnel. Otherwise, it is only a matter of time before the continuity factor, that is so important to long-range success, is lost.

- d) The following activities are proposed, dependent on our ability to schedule the events necessary.

I. The 1986 Interim Meeting of the Board of Governors

A reception will be held on the evening of Wednesday, April 2, 1986, to which officials from the federal government, national health associations, and dental product companies will be invited. This would serve several purposes, in that it would be an opportunity to "kick off" year two of our Awareness Program, Dental Health Month 1986, as well as provide an opportunity for some members of our Board to meet government officials for friendly social and political discussions. The formal part of this program would be a presentation by our President (something witty, eloquent, meaningful and brief). It is felt that if we could accomplish this along with the planned presentation by Mr. Neilson to the Board, we would definitely highlight the priority of Government Relations to the CDA. Possible invitees would be from the areas of Health and Welfare, Revenue Canada (Customs & Excise, Taxation), and Finance.

A dinner has been scheduled for the evening of Thursday, April 3, 1986 featuring a presentation by Mr. Mark Daniels, Deputy Minister of Consumer and Corporate Affairs, regarding the new federal government lobbying legislation. Members of the Board of Governors, Presidents and Chief Executive Officers of corporate members will be invited to participate.

II. June 27-28, 1986 - Executive Council Meeting

We would hope to have an evening session with senior staff and elected officials of the Canadian Medical Association to discuss matters of mutual interest.

III. Prelicensure Conference - February 24-25

The Minister of Health, the Honourable Jake Epp, P.C., has accepted our invitation to address the Tuesday, February 25th luncheon of the Prelicensure Conference. It is hoped that the Government Relations Committee will have the opportunity of meeting informally with him, at that time.

IV. Activities for the post-Summer period to be planned by the end of April 1986.

GOVERNMENT RELATIONS

PART IV - SUMMARY OF ON-GOING ACTIVITIES

Schedule of activities and meetings for the period August 1985 - February 1986

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Dir.	85-08-13	NHW	Bedford	Sr.Dent. Consult.	Establish Contact
Pres. Elect Exec. Dir.	85-08-19	NHW	Nicholson Bedford	ADM/MSB SDC	Meeting Pres. Elect with new ADM
Pres. Elect Exec. Dir.	85-08-19	CMA	Geekie	Dir. Comm	Attend CMA Ann. Mtg. Meeting - Geekie/Holmes
Exec. Dir.	85-08-20	PSC	Baker	Exec. Dir. Appointm.	Review of Senior Structure
Exec. Dir.	85-08-27	IBEW	Myers	Business Agent	Establish Link with J.McCambley, President - C.F.L.
Exec. Dir. D.MacFarlane B. Henderson R. House	85-09-12	CFL	McCambley	President	Union Clinic Program/Third Party Cttee Meeting

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CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Dir.	85-09-23	NHW-Fit. & Amateur Sport	Lesaux	ADM	Participaction Link to Manifest
Exec. Dir. Past-Pres.	85-10-01	RC - Customs	Hanna Oxley	Dir Chief	Meeting to discuss definitions of dental materials and instruments
Exec. Dir. Past-Pres.	85-10-01	FIN	Conway	Spec.Asst. to Minist.	Repeal of Sales Tax Exemption
Executive Director	85-10-08	RC - Excise	Huneault	ADA	Initial Contact - Establishment of Annual Planning and Work Schedule Process
Exec. Dir. Past-Pres. President	85-11-19	NHW-MSB	Obonsawin Nicholson	DG OPS ADM	Dental Therapy Ontario Dental Delivery System
Executive Director	85-12-02	TRANSP	Desjardins	DG - Training	Information Exchange - -Computer Training -Perf. Evaluation
Exec. Dir.	85-12-09	NHW	Bedford	S.D.C.	Update - Proposal Consultation
Exec. Dir.	85-12-19	CCA LAB TRANSP DEF PCO	Various	DM's	Social Gathering - Informal Meeting

GOVERNMENT RELATIONS

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Dir.	86-01-07	DIAND	Laframboise	DG-ORGN	Info - Restructuring of IAND'S Organization
Exec. Dir.	86-01-08	IAE	Various Govt. Reps		Luncheon Meeting IAE Lobbying Legislation - Mark Daniels, DM CCA Guest Speaker
Exec. Dir.	86-01-22	CMA	W. Freamo	Exec. Dir.	Relations CMA/CDA
Exec. Dir.	8-01-23	HWC-Fitness	Lesaux Nicholson Kirkwood	ADM-Fit ADM-MSB DM-HWC	Retirement Reception- Discussed Ministers Partn in Prelicensure with Kirkwood/ Nicholson
Exec. Dir. Mgt Cttee	86-01-24	HWC	Nicholson Obonsawin Ross Chedore Hucker	ADM-MSB DG - OPS A/SCD D-FIN D.Program Transfer	Initial Joint Meeting of Mgt Cttees, held to Review and Define Common Issues
Exec. Dir. President Teteruck Henderson	86-01-28	HWC	Glynn Kealey Moffat Amer Scotcher Rawlings Sullivan	ADM, HSP DG, HS Dir. Inst. & Prof. Serv. Adviser, Dental Health Project Officer Editor - Health Educ. Prog. Officer	" "

GOVERNMENT RELATIONS

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CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Dir.	86-02-03	JUS	Choquette	ADM	N.M.
Exec. Dir. G. Beagrie	86-02-21	HWC WHO	Law Barnes	ASSOC DM	Third World Dentistry

GOVERNMENT RELATIONS

PART V - TAXATION REPORT

(Extract from the February 1986 Taxation Committee Report)

COMMUNICATION NETWORK

The CDA Government Relations Committee has requested that the Taxation Committee identify its communication contacts with the Federal Government. In its activities, the Taxation Committee primarily deals with the Department of Finance and Revenue Canada. However, on occasion the Committee has required communication with certain Members of Parliament - including the Minister of Revenue, and Senators.

The Committee has also been responsible for a formal presentation to the Senate Standing Committee on Banking, Trade and Commerce.

The following is a list of specific federal government contacts:

Revenue Canada

Mr. John Robertson - Director General Audits
Mr. Robert D'Avignon - Director General Appeals
Mr. Robert Hall - Special Audits Division
Mr. David Burton - Special Audits Division
Mr. William McColm - Business Property Income - Rulings
Mr. Mel Hanna - Excise - Interpretations
Mr. André Lapointe - Excise - Interpretations
Mr. Robert Oxley - Excise - Interpretations
Mr. Robert Giroux - Deputy Minister - Customs

Finance

Mr. Raymond Conway - Special Assistant to the Minister
Mr. A. Mitchell - Chief of Pensions
Mr. Weil - Assistant, Chief of Pensions
Mr. Robert Dubrule - Tax Policy
Mr. Gordon Lee - Chief Tax Commodity

Members of Parliaments/Senate

Hon. Perrin Beatty - Solicitor General
Former Minister of Revenue
Former Opposition Critic - Revenue
Canada
Hon. Pierre Bussières - Former Minister of Revenue
Hon. Jack Austin - Senator
Hon. Ray Perrault - Senator
Dr. Bud Bradley - Member (dentist)
Ms Mary Collins - Member (Capilano)

Non governmental communications contacts are as follows:

Professional Associations

-Tax Committee Chairman
Canadian Institute of Chartered Accountants
Canadian Bar Association
Canadian Medical Association

Dental Industries Association Canada

Mr. Stewart Cannon - President

Consultants

Mr. David Matheson, McMillan, Binch - Toronto
Mr. Tom McDonnell, McMillan, Binch - Toronto

Respectfully submitted,

Ron J. Markey, D.D.S., M.S.D.
Chairman
Government Relations Committee

ADOPTION OF REPORT

The Board of Governors receives the report of the Government Relations Committee with appreciation.

COMMITTEE ON SALARIED DENTISTS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Brig.-Gen. J.N. Wright, Chairman - Ontario
 Dr. L. Goldberg, Saskatchewan
 Dr. R.K. Ryan, Ontario
 Dean A. Schwartz, Manitoba
 Dr. C. Tessier, Quebec
 Dr. B. Turcotte, New Brunswick

1. Committee Meetings

Since its last report to the 1985 Interim Board of Governors Meeting, the Committee has held one meeting which took place in Ottawa, on October 1, 1985.

2. Committee Members

All members of the Committee were in attendance at the October, 1985 meeting, including the new member from Sherbrooke, Quebec, Dr. Charles Tessier. Dr. Tessier is a Director of the Association of Community Health Dentists of Quebec, and joins the Committee as the representative of salaried dentists in Quebec.

Since the October meeting, Dr. Ryan has resigned from the Committee, and the President, Dr. Holmes, has appointed Dr. Neil Farrell, Dental Director of the Middlesex-London District Health Unit to replace Dr. Ryan as the representative of salaried dentists in Ontario, as well as the Canadian Society of Public Health Dentists.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

3. Data Bank - Continuing Education Benefits - Portability of Licence - Fringe Benefits

The Data Bank on Salaried Dentists maintained at CDA, now contains information on continuing education benefits offered to salaried dentists by various employers, including Canadian Dental Faculties.

The Committee will be requesting additional information on fringe benefits and other areas of compensation from employers of salaried dentists in the near future.

Current information on Portability of Licence has been received from all provincial licensing bodies and is available at CDA.

The Committee considered a recommendation that the CDA investigate expansion of portability, but it was agreed that the CDA did not have jurisdiction in this area.

4. Malpractice Insurance Coverage

Based on representations from the Committee, agreement has been received from CDSPI to ensure that dentists going into non-clinical practice after termination of clinical practice will maintain malpractice insurance coverage without additional fee for an additional five years.

5. Malpractice Insurance - RCDS(0)

The Committee reviewed the situation whereby public health dentists in Ontario are required to make double payments for malpractice coverage due to the inclusion of such coverage in the licence fees in Ontario. Dr. Ryan informed the Committee that the salaried dentists association in Ontario will be making representations to the RCDS on this matter.

6. Taxable Benefits - Continuing Education Expenses for Salaried Dentists

The Committee reviewed the past efforts of the CDA's Taxation Committee to have continuing education expenses for salaried dentists allowed as a taxable benefit. Although past representations have not received positive replies, the Committee has requested that the Taxation Committee continue in its efforts in this regard, and make further representations to the Department of Finance when deemed appropriate by the Taxation Committee.

The Committee considered a recommendation that CDA prepare a policy on continuing education courses for salaried dentists, but it was agreed that the CDA could go no further than a statement of general policy which was adopted at the 1985 Interim Board Meeting.

COMMITTEE ON SALARIED DENTISTS

7. Formation of a Group/Association of Salaried Dentists

The Committee reviewed resolutions from the Canadian Society of Public Health Dentists concerning the formation of a group/association of Salaried Dentists, and the holding of a Annual CDA Meeting of Salaried Dentists.

On both items the Committee agreed that the CDA's Committee on Salaried Dentists was the appropriate mechanism for addressing concerns of salaried dentists. Individual dentists have the opportunity to present their concerns to the CDA Committee, and where appropriate, these concerns can be brought to the Executive Council and the Board of Governors. The Chairman has expressed these views to Dr. Ellis, President of the Canadian Society of Public Health Dentists.

8. Taxation Article - CDA Journal

At the request of the Committee, an article on taxation as it applies to salaried dentists was published in the December, 1985 CDA Journal.

Respectfully submitted,

J.N. Wright, D.D.S., M.Sc.D.
Chairman
Committee on Salaried Dentists

ADOPTION OF REPORT

The Board of Governors receives the report of the Committee on Salaried Dentists with appreciation.

TAXATION COMMITTEE

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Council Members: Dr. Robert N. Hicks, Chairman
 Dr. Bradley W. Holmes
 Dr. P. Ralph Crawford
 Dr. John R. Robertson

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION1. FEDERAL SALES TAX ON DENTAL MATERIALS

The May, 1985 Federal Budget resulted in amendments to the Excise Tax Act as it applies to dental instruments and supplies. Revenue Canada - Customs and Excise interpretation of these changes resulted in a 10% (11% as of January 1, 1986) Federal Sales Tax being applied to many dental materials and all dental instruments and X-Ray equipment/supplies.

CDA made representation to both Revenue Canada and the Department of Finance, opposing these changes. Letters identifying our position are attached to the October 28, 1985 Taxation Committee Report. Additional correspondence dated December 10, 1985 is attached to this report.

APPENDIX I

The Taxation Committee is pleased to report that, following a review of the issue, Revenue Canada has removed the federal sales tax from most dental materials effective immediately. A letter identifying this specific dental materials exempt from federal sales tax is attached to this report.

APPENDIX II

The Taxation Committee will continue its dialogue with Tax Interpretations - Excise in order to get a definite exempt status for the materials listed in page 3 of the Revenue Canada letter.

TAXATION COMMITTEE

It is noted in the letter that orthodontic materials and appliances will remain taxable. Revenue Canada is suggesting that a change in the Excise Tax is required to have these articles exempt. The Committee will continue discussion with Revenue Canada and, if necessary, with the Department of Finance on this matter. Discussion with Finance will also continue on removing federal sales tax from dental instruments and X-Ray equipment/supplies.

2. REVENUE CANADA CUSTOMS CONFERENCE

CDA was invited to participate in a Customs Conference held in Toronto, on December 16-17, 1985. This conference consisted of representatives from importing and manufacturing industries plus representation from the Customs Brokers Association, the RCMP, the Ontario Provincial Police, the Indian Brotherhood/First Nation Organizations, the Women Against Pornography Group and the Canadian Dental Association. The conference was the first of its kind established to open communication between Revenue Canada - Customs and the public who are affected by the rules and regulations and the Customs Act.

It is significant that the Canadian Dental Association was invited to attend this conference. Our continuous communication with this department through our interests in customs issues resulted in the invitation. In addition, the CDA was asked to recommend a nomination to the Advisory Committee to the minister and the Department on customs issues. While the CDA did not receive a position on the Advisory Committee, Revenue Canada - Customs has agreed to copy CDA on all minutes of the Committee.

A report on the conference is on file with the Executive Director.

3. COMMUNICATION NETWORK

The CDA Government Relations Committee has requested that the Taxation Committee identify its communication contacts with the Federal Government. In its activities, the Taxation Committee primarily deals with the Department of Finance and Revenue Canada. However, on occasion the Committee has required communication with certain Members of Parliament - including the Minister of Revenue, and Senators.

The Committee has also been responsible for a formal presentation to the Senate Standing Committee on Banking, Trade and Commerce.

The following is a list of specific federal government contacts:

Revenue Canada

Mr. John Robertson - Director General Audits
Mr. Robert D'Avignon - Director General Appeals
Mr. Robert Hall - Special Audits Division
Mr. David Burton - Special Audits Division
Mr. William McColm - Business Property Income - Rulings
Mr. Mel Hanna - Excise - Interpretations
Mr. André Lapointe - Excise - Interpretations
Mr. Robert Oxley - Excise - Interpretations
Mr. Robert Giroux - Deputy Minister - Customs

Finance

Mr. Raymond Conway - Special Assistant to the Minister
Mr. A. Mitchell - Chief of Pensions
Mr. Weil - Assistant, Chief of Pensions
Mr. Robert Dubrue - Tax Policy
Mr. Gordon Lee, Chief Tax Commodity

Members of Parliaments/Senate

Hon. Perrin Beatty - Solicitor General
Former Minister of Revenue
Former Opposition Critic - Revenue
Canada
Hon. Pierre Bussières - Former Minister of Revenue
Hon. Jack Austin - Senator
Hon. Ray Perrault - Senator
Dr. Bud Bradley - Member (dentist)
Ms Mary Collins - Member (Capilano)

Non governmental communications contacts are as follows:

Professional Associations

- Tax Committee Chairman
Canadian Institute of Chartered Accountants
Canadian Bar Association
Canadian Medical Association

TAXATION COMMITTEE

Dental Industries Association Canada

Mr. Stewart Cannon - President

Consultants

Mr. David Matheson, McMillan, Binch - Toronto
Mr. Tom McDonnell, McMillan, Binch - Toronto

Respectfully submitted,

Robert N. Hicks, D.D.S., M.S.
Chairman
Taxation Committee

ADOPTION OF REPORT

The Board of Governors receives the report of the Taxation Committee with appreciation.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

December 10, 1985

Mr. André Lapointe
Revenue Canada - Excise
191 Laurier Avenue W. - 9th Floor
OTTAWA (Ontario)
K1A 0L5

RE: Materials used in Reconstructive
Dental Surgery Procedures (Section 19)

Dear Mr. Lapointe:

Enclosed is a list of dental materials used in most routine dental reconstructive procedures. In my attempt to include all materials used, I may have missed a few but the list should represent "90 % level" accuracy.

To assist you in identifying materials used in prosthetic procedures (Section 19), I have also included a list of prosthetic materials. This list is not complete since some materials used for prosthetic procedures are also used for reconstructive procedures (and therefore are included in the reconstructive materials list).

In my October 22, 1985 letter to Mr. Hanna outlining the concerns of the Canadian Dental Association regarding application of federal sales tax following the recent amendments to the Excise Tax Act, I emphasize our concern about the interpretation of orthodontic materials and appliances. Orthodontic treatment involves restructuring the total (or partial) dental structures in the mouth. It is a treatment procedure that treats the total occlusion (fitting of dental units) rather than reconstructing a single dental unit. Materials used in orthodontic treatment should be exempt from tax under Section 19. Their present interpretation as "tools" or "instruments" suggests they are used over again and again (like instruments are) - which is not the case.

.../2

Surgical movement of the upper and/or lower jaws to correct skeleton anomalies is a form of reconstructive surgery performed by either medical (plastic surgeons) or dental (oral surgeons) practitioners. Materials used in this medical reconstructive surgery are exempt from federal sales tax as I identified in Section 19. Orthodontic materials and appliances are required in over 90% of these cases to initiate and complete reconstructive procedure. The orthodontic and surgical procedures are not independent but instead are dependant upon one another. Our Association continues to suggest that orthodontic appliances and materials should be exempt from sales tax under the provision of Section 19.

The Canadian Dental Association requests that you reconsider the present interpretation of orthodontic appliances and materials and rule favorably for exemption under Section 19. I trust we will have an opportunity to discuss this issue further, after you have completed your analysis of reconstructive dental materials.

Please contact me if I can provide you with additional information.

Sincerely yours,



Robert N. Hicks, D.D.S., M.S.
Chairman
CDA Taxation Committee

/ml

DENTAL MATERIALS

- Used in dental reconstructive treatment

Abrasive Discs
Acid gel or solution
(35% - 50%) for etching enamel

Acrylic filling material
Acrylic (and other) tray materials
Amalgam (and other metal) alloys

- Caps
- Pellets
- Powder

Articulating papers and waxes

Cavity liners

Cavity varnishes

Cements

- Calcium Hydroxyde
- Composite luting
- Cyanoacrylate
- Glass ionomer
- Polycarboxylate
- Silicate
- Resin
- Zinc oxide eugenol
- Zinc oxyphosphate

Composition filling materials

- including temporary filling materials

Crowns

- aluminum and plastic
(used as temporary crowns)

Gold

- Dental casting
- Dental alloy solder
- Gold foil and wire

Gutta percha points

Impression materials

Investment materials

Mercury

Pit & fissure sealant

Pins, post and screws

Root canal fillers, sealers and cements

Silicate filling material
Surgical arch bars and wire ties

Waxes

- Casting
- Impression
- Inlay/sticky/utility

DENTAL MATERIALS

- used in dental prosthetic treatment

Acrylic resin material
Artificial teeth

Buffing wheels

Composition metals
Crown & Bridge repair materials

Dental stones
Denture reline materials

Porcelain material

Retraction material
- Cords, packing material, ...

Dr. Robert N. Hicks, D.D.S., M.S.,
Chairman,
Taxation Committee,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario.
K1G 3Y6

Votre référence Your file

Notre référence Our file

CN: 1014/1225
File: 9153-1
Code: 7320

January 15, 1986.

Dear Dr. Hicks:

Thank you for your letters of October 22, 1985 and December 10, 1985, regarding the application of sales tax to dental materials and instruments.

You state that orthodontic articles should be considered as "prosthesis" or "materials for use in reconstructive surgery" and be exempt from sales tax under section 19 of Part VIII of Schedule III to the Excise Tax Act.

Dorland's Illustrated Medical Dictionary, Twenty-fifth Edition defines a prosthesis as:

"an artificial substitute for a missing body part, such as an arm or leg, eye or tooth, used for functional or cosmetic reasons, or both",

Dental prosthesis:

"a replacement for one or more of the teeth and other oral structure, ranging from a single tooth to a complete denture".

In view of the above, an orthodontic article is not a prosthesis but rather an appliance or apparatus to correct deformities or to improve the function of parts of the body, particularly in the mouth or face. Consequently, an exemption for orthodontic articles would require an amendment to the Excise Tax Act. Amendments to the Act are a matter of tax policy coming under the jurisdiction of the Department of Finance.

After a discussion with officials of the Department of Health and Welfare, I share your view that all dental materials did not become subject to sales tax. However, in my opinion, all dental materials are not exempt from sales tax as materials for use in reconstructive surgery under section 19 of Part VIII of Schedule III to the Act. As indicated hereunder, certain dental materials are subject to sales tax as they do not fit into an existing exempting provision in the Act. Other dental materials qualify for exemption under section 5 or section 19 of Part VIII.

... 2

Canada

Department
of National Revenue
Customs and Excise

Ministère
du Revenu national
Douanes et Accises

Dental Materials Subject to Sales Tax

Acid gel or solution
Abrasive disks
Acrylic and other tray materials
Articulating papers and waxes
Dental stones
Impression materials
Investment materials
Pit and fissure sealant
Points, antaneous paper
Retraction material - cords, packing material, etc.

Dental Materials Exempt Under Section 5

Gold - dental casting
 - dental alloy solder
 - foil and wire
Surgical arch bars and wire ties
Acrylic resin material
Artificial teeth
Composition metals
Crown and bridge repair materials
Denture reline material
Porcelain material
Pins, Posts, Screws

Dental Materials Exempt Under Section 19

Amalgam (and other metal) alloys - caps
 - pellets
 - powder
Cavity liners
Cavity varnishes
Composition filling materials
Crowns - aluminum and plastic
Gutta Percha points
Mercury
Root canal fillers, sealers and cements
Silicate filling materials
Waxes - casting
 - impression
 - inlay/sticky/utility

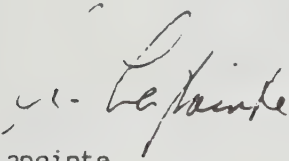
- 3 -

In addition, the following dental materials may qualify for sales tax exemption either under section 5 or section 19, depending upon their use, application or type:

- calcium hydroxyde
- composite luting
- cyanoacrylate
- glass ionomer
- polycarboxylate
- silicate
- resin
- zinc oxide eugenol
- zinc oxyphosphate

I trust that you will find the above satisfactory.

Yours truly,



A. Lapointe,
Tax Interpretations,
Excise.

CONVENTION COMMITTEE

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION1986 Convention - Halifax, Nova Scotia, August 24 - 27, 1986

1. Planning for the 1986 Convention is proceeding on schedule. All keynote speakers have been confirmed and the social program is planned as follows:

Thursday, August 21

Meeting - Presidents & CEO's

Friday, August 22

CDA Board Meeting
President's Installation Dinner and Dance

Saturday, August 23

CDA Board Meeting
Pre Convention Sail

Sunday, August 24

CDHA Fun Run
Convention Registration and afternoon reception
Exhibit move-in day
Evening Registration Party - Market Place Theme

Monday, August 25

<u>AM</u>	Opening Breakfast Keynote speaker - True North Syndicate Exhibits open Grieve Memorial Lecture - Dr. Frank Shamy
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CONVENTION COMMITTEE

-2-

Monday, August 25 (cont'd)

Periodontic and Orthodontic Lecture

- Dr. Norm Boucher
- Dr. Harvey Levitt

Endodontics

- Dr. Phillip Malloy

Pedodontics

- Dr. Michael Cohen

Lunch Walk-About In Exhibit Hall

PM Periodontic and Orthodontic Lecture
- continues

Dental Research - Future Trends

- Dr. Harold Slavkin

Pharmacotherapeutics

- Dr. Trevor Chin Quee

Audio Visuals in Dentistry

- Mr. Bruce Moxley

Projected Clinics

Evening President's Ball

Tuesday, August 26

AM Periodontics
- Dr. Jay Seibert
Peridontal Prosthesis
- Dr. David Garber
Oral and Maxillofacial Surgery
- Dr. David Precious
Practice Development
- Mr. Wilson Southam
Health Screening Update
- Dr. Patrick Blahut

Lunch CDA President's Awards Luncheon

PM Dr. Jay Seibert (cont'd.)
Dr. David Garber (cont'd.)
Mr. Wilson Southam (cont'd.)
Dental Biomaterials
- Dr. Derek Jones
Maxillofacial Prosthetics
- Drs. Robert Hoar and R. Brygider
Table Clinics
Exhibits close

Evening Lobster Bash

CONVENTION COMMITTEE

Wednesday, August 27

AM Removable Prosthodontics
 - Dr. Robert Chapman
 Dental-Legal Implications
 - Mr. Lorne Rozovsky
 Hepatitis and Aids
 - Dr. John Hardie
 Dental Manpower - Status
 - Dr. Ian Vogan

2. An exhibitors guide was sent to all prospective exhibitors on February 14. Booths cost \$800 each to a total of 125 spaces. CDA is targeting for an April 15 deadline date with final payment due July 1, 1986.
3. A convention budget has been developed as appended based on attendance by 750 dental registrants at \$325 per member.
4. The local committee has recommended that there be no simultaneous translation of scientific sessions at the 1986 meeting. Bilingual personnel will assist, where possible, at registration. The committee requested that this matter be brought forward to the Executive Council for information and/or comment.
5. Both the preliminary and final convention programs will be bilingual. It is anticipated that the preliminary program will be mailed to all CDA members in March. Convention publicity began appearing in the CDA Journal in January 1986 and will continue until the convention. Convention literature and registration forms will also appear in the March CDA Communiqué. The chairman of the convention is also writing a personal letter of invitation to all CDA VIP's, and Council and Committee members. This will be mailed in March. In addition, an interview with the convention chairman will appear in Oral Health.
6. For the first time in a number of years, CDA will be offering a children's program at the Halifax meeting.

APP.I

CONVENTION COMMITTEE

-4-

7. Groups meeting in conjunction with the CDA meeting include:

The International College of Dentists (Canadian Section)
The Royal College of Dentists of Canada
The Academy of Dentistry International
The Canadian Academy of Oral Radiology

8. The Sheraton Halifax has been designated as the headquarters hotel. Room reservations for the Executive and Board will be made by CDA staff.

1987 Convention - Quebec City

1. All space being held by the CDA in August 1987 has been cancelled.

1988 Convention - Edmonton

1. Plans for the 1988 meeting are progressing. Dr. Roger Ellis has been appointed chairman. Certain programming decisions await Executive Council's review of the recommendations emanating from the January 11, 1986 meeting of the Advisory Committee on Convention Planning.

ADOPTION OF REPORT

The Board of Governors receives the report of the Convention Committee with appreciation.

1986 CONVENTION BUDGETREVENUES

Exhibits	125 X \$800	\$ 100,000
Spouses' Program	250 X \$100	\$ 25,000
(Lobster Bash calculated separately)		
Auxiliary Transfer		\$ 20,000
Interest		\$ 10,000
Social Tickets		
-Lobster Bash	1,500 X \$40	\$ 60,000
-President' Ball	400 X \$40	\$ 16,000
Registration	750 X \$285	\$ 213,750
(Lobster Bash calculated separately)		
Total		\$ 444,750

EXPENSES

Scientific Program	\$ 50,000
Social Program	\$ 165,380
Spouses' Program (Lobster Bash included)	\$ 35,000
World Trade Center Rental	\$ 21,000
Hosting	\$ 2,000
Exhibitor Hospitality	
(125 X 2 registration party at \$25,	
125 X 2 lobster bash at \$40 = 125 X 130	\$ 16,250
Exhibit Set-up (\$65 x 125 hospitality)	\$ 10,000
Postage	\$ 15,000
Administration	\$ 56,000
Promotion	\$ 50,000
Local Arrangements	\$ 5,000
Sundry	\$ 10,000
Coffee	\$ 6,000
Total	\$ 441,630

ADVISORY COMMITTEE ON CDA CONVENTIONS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. Ron Markey, Chairman
Dr. Michel Jahjah
Dr. Don O'Connor
Dr. Ted Ramage

Staff: Mr. Jardine Neilson, Executive Director, CDA
Miss Linda Teteruck, Director of Educational Services,
CDA
Mrs. Ann Lodge, Consultant, CDA Conventions

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

I. A Successful Format for CDA Conventions

CDA needs to hold a convention for public relations reasons; a national forum is needed to promote the image of CDA as a national organization. Attendance figures and cost were major factors and CDA should plan its meetings to draw as large an attendance as possible and to make money. Convention planning should be a business operation for CDA.

The following suggestions should be considered for future CDA Conventions. These points represent a summary of the Committee's primary recommendations.

1. Inclusion of registration at CDA Conventions as a membership benefit to CDA members. It was felt that CDA should investigate this possibility strongly. If no cost is impossible initially, then very minimal cost should be considered. This is recommended for the following reasons:
 - a) strong inducement to attend meeting for many dentists who do not want to "buy the whole package";
 - b) a very positive and identifiable benefit of CDA membership;

-
- c) it will enhance the image of CDA Conventions to "value conscientious" dentists;
 - d) will eliminate current conflicts with specialty groups seeking complimentary access to exhibit areas as this would now be automatic for CDA members.
2. Non-CDA members would pay a registration fee (full or per diem). Modest fees would also be established for non-members to have exhibit access.
 3. A high quality scientific program offering continuity and long-term planning from year to year.
 4. A more modest social program on a pay as you go basis.
 5. A quality President's Ball with no CDA subsidy.
 6. Enhancement of the availability and quality of auxiliary programs with a view towards increased attendance of auxiliaries. This segment of Conventions could be more successful and profitable.
 7. A locale or program that will appeal to spouses.

2. Convention Committee

CDA needs an ongoing permanent committee to do long term convention planning. This should be an "a-political" committee that does not deal with site selection and CDA/provincial politics, but develops a convention "personality". Its main task will be the long term planning of the scientific program. This committee should be small, three members perhaps, with a permanent secretariat in Ottawa. It should deal with the planning of the scientific program and convention concepts. Its representation should be Canadian in scope with previous convention planning experience as a major criteria for membership. Representation from the convention site should also be considered.

The local committee would be involved in local arrangements endeavours such as social programing. At sites where conjoint meetings are held, long term planning would be done by the provincial associations and CDA's role would be secondary.

The committee cautioned that if such a committee was formed, conflicts might develop with the local, onsite committee, in authorship of the scientific program.

3. Convention Sites and Time of Year

The most difficult issue for discussion was that of meeting sites and conjoint meetings. It was concluded that CDA does indeed lose its profile at conjoint meetings but they are a reality in Toronto and Montreal. It was learned that Vancouver would also be insisting on conjoint meetings in the future. It was concluded that Winnipeg, Regina, and Saskatoon were not attractive sites and Halifax was questionable. It was further concluded that spring was the most attractive time to hold a meeting.

Consequently, the following schedule was recommended:

1986	Halifax
1987	Montreal
1988	Edmonton
1989	Toronto*
1990	Vancouver
1991	Ottawa**
1992	Calgary
1993	Vancouver - FDI
1994	Montreal
1995	Toronto

* Ottawa is being considered as a convention site for CDHA in 1989.

** CDA has been invited to go to Winnipeg in 1991.

It was concluded that it was the role of the Executive Director and CDA's politicians to negotiate convention sites with provincial associations, particularly where there would be conjoint meetings. The following protocol was delineated:

1. CDA Executive Director contacts the Executive Director of the corporate body to discuss meeting prospects and agreeable dates.

-
2. CDA approaches convention bureau for meeting and bedroom sites (except at conjoint meeting sites where this is done by the provincial association).
 3. CDA confirms dates based on agreements with corporate body.

Respectfully submitted,

Ron J. Markey, D.D.S., M.S.D.
Advisory Committee on CDA Conventions

ADOPTION OF REPORT

The Board of Governors receives the report of the Advisory Committee on CDA Conventions with appreciation.

FDI NATIONAL TREASURER

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

REPORT ON THE 1985 WORLD DENTAL CONGRESS

BELGRADE - YUGOSLAVIA

The 73rd Annual FDI World Congress was held on September 21-27 in Belgrade, Yugoslavia at the junction of the Danube and Sava Rivers. The World Congress is held each year for the benefit of individual FDI members and includes an extensive and varied scientific program, provided by reknowned clinicians, scientists and teachers. The broad scope of topics presented provided those who attended a unique exposure to international expertise on many clinical aspects of dental practice.

In conjunction with the World Congress, the 75 member nations of the FDI meet on a formal basis as the General Assembly. The General Assembly is the legislative body of the FDI which convenes annually to decide on the Federation's program and budget and to make policy decisions regarding various problems of international scope confronting the profession. Dr. Bradley Holmes - CDA President, and Dr. Robert N. Hicks - FDI National Treasurer, Canada, represented Canada in this international forum and were the official CDA delegates. Dr. James Wright representing Canada serves as an executive member of the Commission of Defence Forces Dental Services, and acted as CDA alternate delegate, along with Dr. Ralph Crawford. Dr. Bill Thompson - a CDA Past-President - is an elected member of the Council of FDI. Dr. George Beagrie was present in his capacity as Chairman of the Commission on Dental Education and Practice.

Each year, Canadian dentists form a major part of the foreign registrants at this international meeting. This year Canada ranked third highest in a total attendance of 2300 dentists. As usual, the host country "Yugoslavia" ranked first with the U.S.A. placing second. In the past, Canada has always ranked in the top five. Specifically, the attendance figures this year for the leading seven countries were as follows:

Yugoslavia	967
U.S.A.	204
Canada	138
German Federal Republic	122
Japan	91
Sweden	78
Australia	77

FDI NATIONAL TREASURER

Yugoslavia proved to be a warm and welcoming country to those who attended this year's meeting. The alpine areas and the Adriatic coast provided spectacular scenery and beauty to those participants who took advantage of the travel opportunities before and after the Congress. Goods to be purchased - leather, crystal, handicrafts, etc. - were far below Canadian prices while the Yugoslavian white wines were unanimously classified as excellent! The country has a varied history which included occupation by a number of nations. The history left behind many ruins, monasteries, churches, fortresses, etc., which added to the cultural knowledge of those who visited these national treasures.

The working and educational aspects of the FDI meeting are blended together such that activity took place from September 16 through to September 25. The four working groups of the FDI are called Commissions with twenty (20) working groups within them that tackle different problems confronting our profession. They work in the following main fields:

1. Oral Health, Research and Epidemiology:

- This commission gives priority attention to dental caries, periodontal disease, occlusal anomalies and the promotion of oral health.

2. Education and Practice:

- This commission studies dental curricula, teaching methods and the regulation of dental practice.

3. Dental Products:

- This group works in the field of dental materials, instruments and equipment and has been very successful in obtaining international standards.

4. Military Dentistry:

- This commission organizes a Military Conference each year to discuss topics such as standardization of military dental records and oral health care for military personnel.

From these Commissions, open sessions were provided for those attending the FDI World Congress on the following topics:

- Dental Manpower
- Biocompatibility of Metals in Dentistry
- Periodontal Health and Disease in Young People
- Management and Organization of Group Practice
- Equipment for the Provision of Dental Services in Remote Areas.

In the main scientific program, half-day presentations were provided on such topics as:

- Multidisciplinary Approach to Periodontal Therapy
- Emergency in Risk Patients in Dental Practice
- Care of Adolescents with Congenital Cleft Lips and Palates.

Many other topics were presented in one-hour lecture formats.

A number of Canadians made major presentations at the sessions. Some examples are:

- Dental Manpower
Dr. George Beagrie, University of B.C. - Session Chairman
Dr. Bradley Holmes - Presentation
- Bio-Compatability of Metals in Dentistry
Dr. Sheldon Newman, University of Alberta
Presentation and Panel Participant
- Equipment for the Provision of the Dental Services in Remote Areas
Brig.-Gen. James N. Wright, Canadian Forces
Chairman

FDI NATIONAL TREASURER

- Emergency and Risk Patients in Dental Practice
Dr. Tony Parnell, University of Western Ontario
Several presentations

The FDI considered seventy-five papers for presentation in Belgrade. They accepted fifteen papers of which 4 were from Canada.

From the business side of the General Assembly meetings, a number of important items were resolved. A document titled "FDI Policy Document on Lowering Barriers to Oral Health Care" was adopted. It is anticipated that this document will be useful to member nations in their efforts to improve access to dental care in their countries. A further document entitled "FDI Code of Ethics" was completed and should also be helpful in standardizing ethical codes internationally. "Recommendations for Hygiene in Dental Practices" was also discussed with the intent of, once again, establishing recognized standards in this area of practice.

With all of the activity taking place, probably the most significant session for Canada was the open session on "Dental Manpower". Your Canadian delegates attended this session and in fact CDA President, Dr. Brad Holmes, presented Canadian facts and issues at the meeting. While CDA has made positive steps to study and make recommendations on the dental manpower problem in Canada, it was most interesting to listen to representatives from other nations describe their serious manpower problems. Canadian delegates heard of 200 unemployed dentists annually in some European countries. Situations of total dental school closures and other situations of dental class size reductions were discussed. This unique opportunity provided useful background knowledge for us to bring back to our own studies on dental manpower.

This report is only meant to highlight the main activities of this year's World Dental Congress. If there are areas of special interest, please feel free to write to the FDI National Treasurer, c/o CDA Headquarters, 1815 Alta Vista Dr., Ottawa, Ontario, K1G 3Y6, for further information.

Next year's FDI World Dental Congress will take place in Manila, Phillippines, on November 9-15, 1986.

Future FDI Dental Congresses are as follows:

- 1987: Buenos Aires, Argentina: October 24-30
- 1988: Washington D.C., U.S.A.: October
- 1989: Armsterdan, Netherlands: September

At the recent CDA Board of Governors meeting, a decision was made to make an invitation for FDI to hold their World Dental Congress in Vancouver, B.C., in 1993. It is anticipated that our invitation will be voted upon at the Manila meeting in 1986.

Respectfully submitted,

Dr. Robert N. Hicks, D.D.S., M.S.,
National Treasurer

ADOPTION OF REPORT

The Board of Governors receives the report of the FDI National Treasurer with appreciation.

STATEMENT OF WORK: Independent Review of Dental Services

THAT Medical Services Branch, Health and Welfare, Canada wishes to conduct an independent review of its dental services program in the form of a comprehensive evaluation of:

- i. the levels of dental service provided in Regional programs;
- ii. modes of dental health care delivery presently utilized;
- iii. costs of such health care in terms of operating dollars, person-years and non-insured expenditures.

AND consider this evaluation and its recommendation in light of potential improvements to the dental health of the Indian and Inuit people of Canada as well as improvements in the efficiency, effectiveness and economy of resources presently committed to this service.

Two independent contractor(s) should be engaged by this Branch to conduct this review according to the following terms of reference:

1. To examine the current practices and available Regional guidelines for the provision of treatment and preventive dental services in private dental offices and field dental programs for both the child and adult Indian and Inuit population of Canada.
2. To review the requirement for standard interpretation and application in the provision of dental health services under the Indian Health policy.
3. To estimate the relative cost and program implications of transferring the whole or part of the dental services program, including the National School of Dental Therapy to:
 - a) local community, Band or regional council control;
 - b) private third party contractor;
 - c) territorial government(s);
 - d) maintenance of the existing system.

4. To examine the rate of transfer for dental services in a sample of representative regions and predict the residual role of Medical Services Branch.
5. To review the concepts and rationale of the dental therapy program; to assess the future role of the National School of Dental Therapy and of dental therapists; to assess the implications of transfer on federal dental therapists; to assess the program implications of transferring the National School of Dental Therapy and dental therapists (refer to #3).
6. To investigate the indemnity and possibility of professional liability for dental therapists employed or contracted by any agency other than the Crown.
7. To make appropriate recommendations and jointly submit a written report to Minister of the Department of National Health and Welfare on or before May 30, 1986 based on these findings.

DR. FREDERIC GLADSTONE GOLLOP - 1897-1984

Born 1897, at Georgetown, Ontario, the son of a pioneer dentist in the Georgetown area. Graduated University of Toronto, Class of 1920. Practised for a short period in Georgetown and in the town of Malton, Dr. Gollop moved to the city of Ottawa in the mid 1920's and set up private practice general dentistry. Retired in mid-1970's, after more than 50 years of dedicated service.

Married to Pearl Campbell, the Gollops lived at 2013 Alta Vista Drive for many years. Mrs. Gollop died in November of 1982.

A quiet, kindly man, Dr. Gollop was said to be dedicated to the principle that the patients well-being is primary and dedication to self secondary. Always in solo practice, Dr. Gollop throughout his dental career is reported to have had a "charitable way in relationships with patients" and throughout the years was dentist to numerous Ottawa politicians of reknown.

A long time member of the Ottawa Dental Society, Dr. Gollop knew the necessity of the dentist being the "continuous student" and at all times kept himself abreast of the ever changing, ever expanding dental knowledge.

Dr. Gollop had a particular love of horses, a trait he inherited from his own father who displayed show horses. Amongst his hobbies was a fondness of art; sketching and drawing. Friends who visited the Gollops in their home were fondly shown an excellent collection of antiques and early Canadiana of which the Gollops had considerable knowledge. A particularly prized item was a grandfather clock, now over 250 years old, which Dr. Gollop inherited from his father, and now belongs to Mr. and Mrs. Joseph May.

The Gollops had no children of their own but readily "adopted" young people who visited them. In later years prior to his death, Mr. and Mrs. Joseph May of Woodlawn Avenue in Ottawa were frequent attendees to Dr. Gollop's needs and cares and the Mays speak fondly of Dr. Gollop's interest in young people and their activities. The May children, Courtney, Danielle and Sean reported how Dr. Gollop always displayed a singular interest in any endeavor they spoke about. A proud but very shy man, Dr. Gollop resisted to the very end the sincere pleas of the May family to move into their home in order that Dr. Gollop's needs might best be served.

Any conversations, with Dr. Gollop's dental friends always reveal that Dr. Gollop was concerned about dentistrys professional image. With his dedication to the profession, Dr. Gollop was always upset and hurt whenever dentists were unfairly criticized and maligned. Dr. Gollop lived a lifetime of professional dedication and it was this intrinsic characteristic that prompted Dr. Gollop to make the Canadian Dental Association recipient of a magnaninous gesture - the beneficiary of \$66,000 - toward the "well being of the profession".

Although at time of printing, final details have not been completed, it is expected that the \$66,000 legacy will be invested and the proceeds there of, will be to provide fellowships for graduate studies in Dental Research.

REPORT EXECUTIVE COUNCIL RE: DR. FREDERIC GOLLOP BEQUEST

With the bequest of Dr. Frederic Gollop, of \$66,000, there is now an opportunity to meaningfully contribute to Dental Research.

In 1920, fifteen dentists mainly from the Toronto, Hamilton Area, created "The Canadian Dental Research Foundation" for the purposes ...

- to carry out among Dental Associations and Dental Colleges an intensive study of perplexing problems which confront the profession ... where possible the work to be done by recent graduates. For this purpose, fellowships are to be established in the Dental Colleges;
- to give assistance ... to members in their efforts to find satisfactory solutions to difficult problems which are met in practice;
- to give financial and other assistance to worthy members ... as may be struggling with great problems and making sacrifices far beyond their means;
- in short, to serve humanity and the dental profession by investigation, study and research.

This Trust Fund was originally administered by National Trust but in 1979 administration was turned over to CDA, and presumably the Board of Governors via Executive Council.

The records of past years indicate that no capital enlargement of the fund was evident and that the interest has been used to award a "research prize" of \$1,000 plus a plaque to the recipient and university. In 1979, the capital was \$24,377 and in 1984, \$28,300.

If the Gollop bequest of \$66,000 is added to the Dental Research Foundation then the capital would approximate \$94,000. The expected interest could well approach \$9,000 - \$10,000 per year.

Although Dr. Gollop left no particular instructions for the use of his bequest, it was evident from conversations with his executor, Mr. Joseph May, and with his confreres from the Ottawa Dental Society, that Dr. Gollop would be very happy if his bequest went toward fulfilling one of the original purposes of the Research Foundation "... in short, to serve humanity and the dental profession by investigation, study and research ..."

Several possibilities are available in this venture. One would be to use the entire sum of interest, \$9,000 or \$10,000 per year, to fund a Research project in one of our ten (10) universities. Another would be to use the interest to support Research in all ten (10) Dental Colleges, ie. about \$1,000 each, for a total of \$10,000.

In the first instance, a large sum of \$9,000 - \$10,000 could be a "God-send" to a particular investigator but it would necessitate the fact that a worthy project could be allocated every year. On the other hand, it could be assumed that each of the ten (10) universities would welcome \$900 or \$1,000 a year toward some research endeavor in the faculty ... often to be used as "seed money" to mount larger projects.

In either, or any case, it would be nice if the original intents of the Foundation were followed ... "where possible the work to be done by recent graduates ... and fellowships be established in the Dental Colleges".

The awards could well be named "The Frederic G. Gollop Fellowship".

It is also recommended that a specific Committee of Executive Council be established to administer, publicize and report to Executive Council on all aspects of Trust Funds. There is a tendency to "overlook" the Trust Funds and their original intents. Three Trusts are involved:

- The Library Trust Fund
- The Canadian Dental Research Foundation
- The Grieve Memorial Lectureship Fund.



NOV 15 1985

Dr. Bradley Holmes,
President,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario.
K1G 3Y6.

Dear Dr. Holmes:

Dental Profession Act

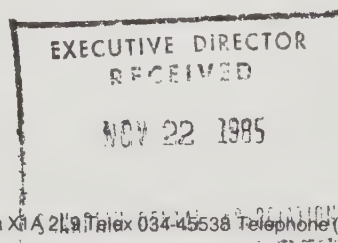
The Government of the Northwest Territories recently amended its Dental Profession Act. The amendments were required to bring the Act more in line with the conditions of the Canadian Charter of Rights and Freedoms and establish registration criteria more in keeping with the trend of other jurisdictions.

In summary, dentists wishing to practise in the Northwest Territories must show evidence that he/she

- a) is registered as a dentist in a province or the Yukon Territory or holds a certificate of qualification as a practising dentist issued by the National Dental Examining Board of Canada or its predecessor, the Dominion Dental Council of Canada, and
- b) has not been removed from the Register of Dentists in any province or territory or had his privileges as a practising dentist suspended for disciplinary reasons.

In recognition of our vast geographic area, the sometimes difficult task of recruiting dentists to the north and the need to ensure that dentistry is available to N.W.T. residents, we have inserted an exception clause. The clause reads as follows:

The Commissioner may allow a person who does not qualify under paragraph 5(1)(a) to be registered in the Dental Register for a single period of three years, for the purpose of giving the person an opportunity to obtain the necessary qualifications under paragraph 5(1)(a), where



...2

- (a) the person satisfies the Commissioner that he is professionally qualified and proficient to practise dentistry; and
- (b) the Commissioner is satisfied that special circumstances exist that necessitate registering such a person.

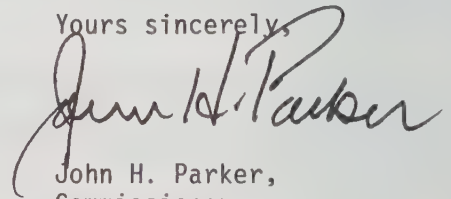
It is in relation to this clause that I am requesting the assistance of the Canadian Dental Association. I have responsibility to determine the professional ability and proficiency and evaluation of academic and professional qualifications of candidates requesting exception. Since the Dental Association in the Northwest Territories is very limited in size and does not have the expertise to examine credentials I am requesting the assistance of your association in this area.

I estimate the number of applications for temporary registration to be limited as it is our intention to utilize the clause only when the Northwest Territories finds itself in a situation where efforts to recruit dentists who are eligible for registration have failed and there is a requirement for additional dentists.

If your Association is willing to carry out the described role could you indicate a time frame under which requests would be handled.

I look forward to your response.

Yours sincerely,



John H. Parker,
Commissioner.

cc: Minister of Health



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

December 11, 1985.

Mr. John H. Parker,
Commissioner,
Government of the Northwest Territories,
Yellowknife, N.W.T.
Canada, X1A 2L9.

Dear Mr. Parker:

Thank you for your letter of November 15th and the information on recent amendments to The Dental Profession Act for the Northwest Territories. I understand the problem of providing essential health services in remote areas and appreciate your courtesy in contacting the Canadian Dental Association for assistance in dealing with applications for temporary registration.

While CDA would in no way wish to be interpreted as supporting the general use of unlicensed dental personnel, we do recognize that you face special circumstances where the discretion granted under paragraph 5(1)(a) may be essential. On the limited basis you specify, our Association is prepared to co-operate with you by providing advice on the general level of qualification offered by candidates under consideration in such circumstances.

It will be necessary to establish a CDA mechanism for dealing with such requests, possibly in conjunction with the National Dental Examining Board of Canada. I would estimate that we could normally complete review of qualifications within approximately two to three weeks. CDA employs electronic mail (Envoy 100 service) which would expedite conclusions reaching you as soon as the reviews are completed (if you have access to Envoy 100). Only experience will tell if this is realistic, but we certainly would do our best to reply as quickly as possible.

Since there would be real costs involved in utilizing the services of a reviewer in each instance, we would propose a review fee of \$50 per candidate for your consideration.

...2

-2-

I hope this response is helpful and that you will let me know if you wish us to be involved or if the general approach suggested needs to be changed to suit your needs.

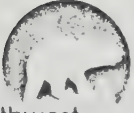
Yours sincerely,

Bradley W. Holmes, D.D.S.
President.

:dh

c.c. Dr. A. Schwartz,
Dr. G. Kravis

c.c. B. Henderson
Dr. Holmes



Northwest
Territories Justice and Public Services

January 10, 1986

Canadian Dental Association
1815 Alta Vista Drive
Toronto, Ontario
K1G 3Y6

Attention: Bradley W. Holmes
President

Dear Dr. Holmes:

The Consumer Services Division of the Department of Justice is responsible for the administration of the Dental Profession Act in the Northwest Territories. Your letter of December 11th to Commissioner Parker regarding the evaluation of documents has been passed to this office to proceed and work out the details.

We would like this procedure to start as soon as possible and with as little confusion as possible so perhaps the best way is for me to ask questions.

- (a) What documentation, educational or otherwise, is required for your review and evaluation? Are these to be originals, certified copies or are xeroxed copies sufficient?
- (b) Where and to whom are we to send the information?
- (c) Applicants must be eligible to write the National Examinations; Are there any universities, schools, institutes or even countries where the quality of education is not of a standard to qualify an individual to write the examinations? If there are we could advise prospective employers or applicants and there would be no need of an evaluation by yourselves.
- (d) Would it be possible for the written portion of the examination to be taken in the N.W.T. under supervision?
- (e) Do you have information pamphlets that we could have to give these persons, as they will be told when they are licensed that the examinations must be written and passed in a specified period of time. Is there application forms, text books, etc. available to persons wishing to take the exams?

.....2

- 2 -

I have spoken with our Communications people and have been told that the Government does not have Envoy 100 Services. The Government does have telex machines and a Pitney-Bowes 8900 which takes groups 3,2,1; as far as I can tell this is something like a telecopier, we do not have these in our office.

It may be simpler, in the long run, if the results were first conveyed to us by telephone (collect) followed by a special delivery letter. At that point we would know the results immediately and could commence whatever action was necessary.

As stated previously we would like to get the system under way as soon as possible as we have received some documentation on two individuals registered with the General Dental Council. Immigration has approved one and apparently we will be hearing soon with regards to the other.

If you wish further information from us please call me collect at (403)-920-8058.

Yours truly,

A handwritten signature in cursive script, appearing to read "Helen Roberts".

Helen Roberts (Mrs.)
Registrar,
Professional Licensing.

INTRODUCTION OF 90-DAY LTD PLAN

- o PROGRAM IS TO BE IMPLEMENTED, SUBJECT TO ACCEPTABLE RATES

- o IMPERIAL'S RATES HAVE NOW BEEN DECREASED

<u>AGE</u>	<u>ORIGINAL QUOTATION</u>	<u>REVISED BY NEGOTIATION</u>	<u>NEGOTIATED REDUCTION</u>	<u>RATES AS % OF 30-DAY RATES</u>
UNDER 25	8.22	6.58	20%	60%
25 - 29	9.24	7.76	16	63
30 - 34	10.52	9.26	12	66
35 - 39	12.29	11.31	8	69
40 - 44	17.54	16.61	5	71
45 - 49	22.50	21.90	3	73
50 - 54	28.73	28.73	-	75
55 - 59	34.98	32.80	6	75
60 - 64	40.58	35.81	12	75
65 - 69	35.06	29.22	17	75

- o RECOMMEND 90-DAY PLAN WITH NEGOTIATED RATES



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

SCHEDULEPRESIDENT - CANADIAN DENTAL ASSOCIATIONDR. B. W. HOLMES1985

Oct. 2	Presidents & CEO's Annual	Ottawa
Oct. 3-4	Annual CDA Bd. of Govs.	Ottawa
Oct. 4	Executive Council	Ottawa
Oct. 5	CDSPI Board/Annual	Ottawa
Oct. 16	Toronto All Societies	Toronto
Oct. 17	Provincial Dental Directors	Quebec City
Oct. 18-19	Manpower Symposium	Toronto
Oct. 23	Meeting Manifest	Toronto
Oct. 24	U. of T. Info. Night	Toronto
Oct. 25-26	Society Meeting	Dryden
Oct. 28	CDSPI	Toronto
Nov. 2-6	American Dental Assoc.	San Francisco
Nov. 14-15	Management Committee	Ottawa
Nov. 16-18	Executive Council/Retreat	Deerhurst
Nov. 18	CDA/CDSPI Mgt.	Willowdale
Nov. 19	Meeting Mr. Nicholson/Obonsawin	Ottawa
	Health & Welfare	
Nov. 19	Stratford Society Meeting	Stratford
Nov. 28	Toronto Academy Winter Clinic	Toronto
Nov. 29-30	ODA Board	Toronto
Nov. 30	Opening Ceremony, New Wing, Faculty of Dentistry U of T	Toronto
Dec. 5	Meeting Rep. Sask. College	Toronto
Dec. 6	Meeting Nfld. Dental Rep.	Toronto
Dec. 6	Conf. of Prov. Licensing Bodies	Toronto
Dec. 7	Membership Committee	Ottawa

PRESIDENT'S SCHEDULE - CONTINUED

1986

Jan. 16-18	Manitoba Annual	
Jan. 24	Meeting-Medical Services	Ottawa
Jan. 25	Manpower Committee	Ottawa
Jan. 28	Health Services & Promotion Br.	Ottawa
Feb. 11	Vancouver & District Dental Society 1986 General Meeting	Vancouver
Feb. 19-20	Management Committee	Ottawa
Feb. 21-22	Executive Council	Ottawa
Feb. 24-25	PreLicensure Conf.	Montreal
Feb. 28	Exec. Meeting-FDI 1993	Vancouver
Mar. 1	University of Alberta	Edmonton
Mar. 3-5	B.C. College Convention	Vancouver
March 21-22	At.Provs. Exec.	Halifax
April 2	Call the President Day	Ottawa
April 3	Annual Specialty Meeting	Ottawa
April 4-5	Interim Board of Govs.	Ottawa
April 12	Prof.Resource Utilization Committee	Ottawa
April 19	PEI Annual	Charlottetown
May 9-10	ODA Board	Toronto
May 10	New Brunswick Annual	Moncton
May 11-14	ODA Convention	Toronto
May 25-29	Les Journées dentaire	Montreal
June 5-7	College of Dental Surgeons of Sask. Convention	Swift Current
June 13-14	Nfld. Annual	Grand Falls
June 13	Nova Scotia Convention	Halifax
June 25-26	Management Committee	Ottawa
June 27-28	Executive Council	Ottawa
July 30-Aug.2	Alberta Convention	Grande Centre

PRESIDENT'S SCHEDULE - CONTINUED

August 7-8	CFDS Grad Ceremony	Borden
August 21	Presidents & CEO's	Halifax
August 22-23	CDA Annual Board	Halifax
August 24-27	CDA Convention	Halifax

Rev. 1/86

*Tentative

COUNCIL ON CONSTITUTION AND BY-LAWS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. G.H. Peacock, Saskatchewan - Chairman
 Dr. M.J. Crompton, New Brunswick
 Dr. B. Jackson, Ontario
 Dr. M.J.R. Leitch, British Columbia

 Dr. E.F. Allison, Alberta - Executive Liaison

1. Council Meetings

Since the 1985 Annual Board of Governors Meeting, no meetings of the Council have taken place, rather all items requiring action were handled through written correspondence. On January 16, 1986 a Conference Call took place during which council business was also addressed.

ITEMS REQUIRING BOARD ACTION

At the 1985 Annual Meeting of the Canadian Dental Association Board of Governors, Notice of Motion was directed to the Council on Constitution and By-Laws concerning Life Membership and Supporting Membership. These Notices of Motion are quoted here-under for your information.

2. Notice of Motion - Life Membership

THAT the Life Membership Category be revised with the direction that in order to obtain a CDA Life Membership a dentist shall have been an Active or Affiliate member of the CDA in good standing for a minimum of 40 years regardless of age of applicant.

(The above notice of motion was also directed to the Membership Committee and both bodies requested to bring an amendment to the 1986 Interim Meeting for consideration).

COUNCIL ON CONSTITUTION AND BY-LAWS

3. Notice of Motion - Supporting Membership

THAT the Council on Constitution and By-Laws of the CDA be requested to present an amendment to the 1986 Interim Meeting of the Board of Governors whereby Sections 6 and 8 under Section V (Membership) and Sections 6 and 8 under Section VI (Privileges of Members) are combined under the single category of Supporting Membership.

4. Following a review of the above Notices of Motion, your Council recommends:

RESOLVED:

86.19 THAT Article V - Membership be approved as amended.

APPENDIX I

ADOPTED

5. Your Council further recommends:

RESOLVED:

86.20 THAT Article VI - Privileges of Members be approved as appended.

APPENDIX II

ADOPTED

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

6. Council received correspondence from the Executive Council respecting a request to examine the Constitution and By-Laws as they deal with appointments to the Executive Council and elections to the Management Committee. A response to this correspondence was forwarded to Executive Council for their consideration.

COUNCIL ON CONSTITUTION AND BY-LAWS

-3-

7. Canadian Academy of Periodontology - Constitution and By-Laws

Your Council had previously reviewed their revised document and were in agreement that there did not seem to be any part of it which would be in conflict with the Constitution and By-Laws of the Canadian Dental Association. The Canadian Academy of Periodontology was informed of this information, and the revised document has subsequently been formally approved by the Academy.

8. Canadian Society of Public Health Dentists

Correspondence has been received from the Canadian Society of Public Health Dentists, wherein Council was informed of a proposal to amend their By-Laws. The proposed amendment was believed not to be in conflict with the Constitution and By-Laws of the Canadian Dental Association and an appropriate response was provided to the Society should they wish to proceed to receive their memberships approval.

Respectfully submitted,

G.H. Peacock, D.D.S.
Chairman
Council on Constitution and
By-Laws

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Constitution and By-Laws with appreciation.

CDA CONSTITUTION & BY-LAWS**CURRENT****ARTICLE V - MEMBERSHIP****Section 5 - Life Members**

Any dentist who has practised his or her profession for at least 40 years or who, on attaining his or her sixty-fifth birthday has been a member in good standing of the Association for half of his or her practice years, with the last three consecutive; will on approval of the Executive Council become a Life Member of the Association.

Section 6 - Associate Members

Any dentist in good standing, graduated by a Canadian faculty of dentistry, but not licensed to practise in a Province of Canada, or who has retired from practice, or who qualifies through special mitigating circumstances, may apply to the Executive Council to be granted Associate membership and shall become an Associate Member upon being admitted by the Executive Council and upon payment of the appropriate fee.

Section 7 - Student Members

Any undergraduate student in an accredited dental school in Canada who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

Section 8 - Supporting Members

A person having an interest in the well-being of the Association and who does not otherwise qualify as an Active, Affiliate, Honorary, Life, Associate or Student Member shall be eligible to apply for admission as a Supporting Member and shall become a Supporting Member on being admitted by the Executive Council and upon payment of the appropriate fee.

CDA CONSTITUTION & BY-LAWS

REVISED

ARTICLE V - MEMBERSHIP

Section 5 – Life Members

Any dentist who has been a member of the Canadian Dental Association in good standing for a minimum of forty (40) years regardless of age of applicant will, with the approval of the Executive Council, become a Life Member of the Association.

Section 6 – Student Members

Any undergraduate student in an accredited dental school in Canada who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

Section 7 – Supporting Members

Any dentist in good standing who is no longer licensed to practise in Canada, or who is fully retired from dental practice, teaching or administration or who presents special mitigating circumstances, or any other person having an interest in the well-being of the Association and who does not otherwise qualify, shall be eligible to apply for admission as a Supporting Member and shall become a Supporting Member upon approval by the Executive Council and payment of the appropriate fee.

CDA CONSTITUTION & BY-LAWS

CURRENT

ARTICLE VI - PRIVILEGES OF MEMBERS

Section 6 - Associate Members

An Associate member in good standing shall have the same rights and privileges as an Affiliate member.

Section 7 - Student Members

- a) A Student member in good standing shall be entitled annually to a certificate of membership, to receive the Journal of the Canadian Dental Association, to attend scientific meetings of the Association on payment of applicable registration fees and to enjoy all other facilities of the Association.
- b) A Student member in good standing shall be eligible for election to any office or agency of the Association except as otherwise provided in the By-Laws and except that he shall not be entitled to serve as a member of the Executive Council.
- c) A Student member shall be entitled to vote in the election of members of the Council on Student Affairs.

Section 8 - Supporting Members

A Supporting member in good standing shall be entitled annually to receive a certificate of membership and the Journal of the Canadian Dental Association. He shall be entitled to attend scientific sessions of the Association on payment of applicable fees and to enjoy such other services as are authorized by the Executive Council. A supporting member shall not be entitled to vote on any question arising at any meeting of members of the Association, but shall be able to participate in the insurance and investment programs of the Association.

Section 9 - Entitlement to Vote

Subject to the provisions of the Canada Corporations Act, only the Corporate members shall be entitled to vote at a meeting of members, the number of votes to which each such Corporate member is entitled shall be determined in the same manner as provided in Article VIII.

REVISED

ARTICLE VI - PRIVILEGES OF MEMBERS

Section 6 - Student Members

- a) A Student Member in good standing shall be entitled annually to a certificate of membership, to receive the Journal of the Canadian Dental Association, to attend scientific meetings of the Association on payment of applicable registration fees and to enjoy all other facilities of the Association.
- b) A Student Member in good standing shall be eligible for election to any office or agency of the Association except as otherwise provided in the By-Laws and except that he shall not be entitled to serve as a member of the Executive Council.
- c) A Student Member shall be entitled to vote in the election of members of the Council on Student Affairs.

Section 7 - Supporting Members

A Supporting Member in good standing shall be entitled annually to receive a certificate of membership and the Journal of the Canadian Dental Association. He shall be entitled to attend scientific sessions of the Association on payment of applicable fees and to enjoy such other services as are authorized by the Executive Council. A Supporting Member shall not be entitled to vote on any question arising at any meeting of members of the Association, but shall be able to participate in the insurance and investment programs of the Association.

Section 8 - Entitlement to Vote

Subject to the provisions of the Canada Corporations Act, only the Corporate Members shall be entitled to vote at a meeting of members, the number of votes to which each such Corporate Member is entitled shall be determined in the same manner as provided in Article VIII.

DENTAL MATERIALS AND DEVICES

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS APRIL 1986

MEMBERS: Dr. R.Y. Barolet, Chairman, Québec
Dr. P.C. Desautels, Québec
Dr. L.N. Johnson, Ontario
Dr. D.W. Jones, Nova Scotia
Dr. S. Newman, Alberta
Dr. R.H. Roydhouse, British Columbia
Dr. D.C. Smith, Ontario
Dr. P.T. Williams, Manitoba

1. Council Meeting

One meeting took place at the Ottawa headquarters on November 8, 1985 since the last report to the 1985 Board of Governors meeting held in October 1985.

Items For Information - Not Requiring Board Action

2. CDRF Award

Following the motions accepted at the last Board meeting, arrangements are proceeding to advise possible candidates of the new Terms of Reference for the Canadian Dental Research Foundation Award. Invitations to submit for the 1987 Award will be sent to about 100 candidates. The deadline for submissions will be December 1, 1986. An article will be prepared for publication in the Journal explaining the Award and the revised protocol for submissions of articles for consideration.

A request has also been made to the CFDE to obtain further funding for the Canadian Dental Research Foundation Fund.

3. Dental Implants Certification, Health Protection Branch

Following the meeting held between representatives from CDA, the dental industry and the Health Protection Branch, an Information Letter (#696) was issued excluding restorative dental materials from the dental implant legislation. A letter has been sent to the Minister Mr. Epp, November 27, 1985 thanking him for the action taken by his Ministry and assuring him that the Association was ready to continue co-operating with his officials to achieve appropriate regulations pertaining to dental materials. The Minister has since confirmed that new regulations are not contemplated and that CDA will be asked for input should further regulations be developed.

A CDA representative has been appointed to a Health and Welfare Dental Task Force which will study the need for regulations relating to dental implants as defined by our profession. The Board will be informed, in future Council reports, of the results of the work of this task force.

A brief article, "CDA Secures Changes in Regulations Defining Dental Materials as Implants" has been published in the CDA Journal.

4. CDA/CSA Certification Program

Following the motion passed at the October Board meeting to provide a loan to the program for startup costs, two laboratories are preparing detailed cost estimates for the required equipment and supplies.

The first material that will be considered for testing/certification will be dental amalgam. Industry has indicated a willingness to participate in such a program and to contribute to the costs of testing.

A meeting between CDA and CSA officials will be arranged to discuss implementation of the program along with the guidelines and terms of operation.

5. ISO/TC 106

A meeting of the organization for international standardization (ISO) was held in Milan, Italy last October. Six members from Council were present at these meetings.

6. Mercury Toxicity

Following the correspondence received from Dr. Murray Vimy, he was invited to come to the Council meeting to make his views better known to the members. Unfortunately, Dr. Vimy declined the Council's invitation.

Council reviewed the available documentation and reaffirmed its conclusion that current research on the use of silver dental amalgam suggests that amalgam continues to demonstrate clear advantages in many applications over other restorative materials and that significant evidence of patient risk associated with its use has not been demonstrated. Most therapeutic materials involve potential side effects or risks as well as benefits and dentists are trained to be on their guard for these reactions at all times.

Respectfully submitted

Ralph Y. Barolet,
Chairman,
Council on Dental Materials & Devices

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Dental Materials and Devices with appreciation.

COUNCIL ON EDUCATION & ACCREDITATION

REPORT TO THE 1986 INTERIM BOARD OF GOVERNORS

MEMBERS: Dr. A. Schwartz, Chairman, Winnipeg
Dr. G. Beagrie, Vancouver
Dr. M. Boyd, Vancouver
Dr. G. Burgman, Kirkland Lake
Dr. D. Beck, Richmond, B.C.
Dr. H. Dick, Edmonton
Dr. B. Graham, Halifax
Dr. M. Jahjah, Montreal
Dr. N. Layton, Truro,
Mrs. Kate MacDonald, Halifax
Dr. E. W. McIntyre, Edmonton
Mrs. Marlane Paquin, Vancouver
Dr. K. F. Pownall, Toronto
Miss Jackie Robarts, Welland
Dr. G. Thordarson, Vancouver
Dr. G. Thompson, Edmonton
Dr. I. Vogan, Halifax

Dr. R. Markey, Executive Liaison, Vancouver

1. Council Meetings

The Council on Education and Accreditation has not met since the last report to the CDA Board of Governors, and it is not customary for the Council to report to the Interim Board meeting. However, through its committees, the Council has been very active and it is anticipated that Council's report to the CDA Annual Meeting will be exceptionally heavy. For this reason, and to provide greater opportunity for input on matters of interest to CDA's corporate members, two substantial documents which will be presented for approval at the annual meeting are tabled for information.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

2. Brief on Reciprocity

The Council on Education and Accreditation also presents for review the attached brief on a reciprocal agreement between the Council on Education of the American Dental Association and the CDA Council on Education and Accreditation. It is

COUNCIL ON EDUCATION & ACCREDITATION

felt that Executive Council should approve the submission of the brief as a response to concerns expressed by ADA with respect to differences in treatment, for purposes of licensure, of graduates of accredited Canadian and American education programs in dentistry. The brief has been prepared following consideration of replies to a questionnaire sent to CDA corporate members and dental educators across Canada. The response must be presented to ADA by March 15th.

APPENDIX I

Executive Council accepts and approves the Report of the Ad Hoc Committee on Reciprocity as a basis for negotiation.

3. Draft - Competency Profiles

A Committee of the Council on Education and Accreditation has completed its assignment of overseeing the preparation of draft Competency Profiles related to Dental Hygiene and Dental Assisting.

These copies should be reviewed by corporate members and comments and suggestions on any revisions sent to Mr. Brian Henderson, Director of Accreditation, prior to the end of April, 1986. The Council on Education and Accreditation will take written responses into account during its review of the draft profiles as its meeting in June.

Respectfully submitted,

Dr. Arthur Schwartz
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Education and Accreditation with appreciation.

BRIEF ON RECIPROCITY

BACKGROUND

At its May 1984 meeting, the Council on Dental Education of the American Dental Association reviewed correspondence from a Canadian citizen who had completed his dental and specialty education in the United States. The correspondence outlined the individual's concern that he was required to complete the National Dental Examining Board of Canada certification examinations despite the fact that he had graduated from an accredited program, recognized under the terms of a reciprocal agreement, by both the American Dental Association and the Canadian Dental Association. He pointed out that current graduates of accredited programs in Canada were granted NDEB certification without the necessity of completing NDEB examinations.

The ADA Council on Education directed that the correspondence be transmitted to the Council on Education and Accreditation of the Canadian Dental Association along with a request that it review with the National Dental Examining Board the reciprocal agreement in an effort to assist citizens of Canada who receive their dental education in the United States. The CDA Council on Education and Accreditation, at its June 1984 meeting adopted a resolution "That the NDEB be requested to reconsider the present examination process of graduates of accredited American dental schools". Subsequently, Dr. Mario Santangelo, in consultation with Dr. Don Allen, directed correspondence to Dr. Gundega Kravis, Registrar for the NDEB, on July 24th, 1984. The correspondence requested an opportunity to discuss the issue with the National Dental Examining Board of Canada during its November 1984 meeting. The National Dental Examining Board of Canada,

reviewed the request and concluded that the reciprocal agreement is between the Council on Education and Accreditation of the Canadian Dental Association and the Council on Dental Education of the American Dental Association.

Consequently, the NDEB referred the matter to the CDA Council on Education and Accreditation. Dr. Ken Bentley, then Chairman of the Canadian Dental Association Council on Education and Accreditation, subsequently arranged a meeting between Drs. Allen and Santangelo and members of the CDA Council on Education and Accreditation for January, 1985. The meeting was held at CDA in Ottawa on January 11th, 1985. Dr. Arthur Schwartz, meeting Chairman, and Dr. Henry Dick, NDEB representative on Council, represented the interests of Canadian accreditation and licensure. Dr. Gundega Kravis and Mr. Brian Henderson attended as staff resources.

During the meeting it became apparent that there were differences between the Canadian and American perspectives on the nature of the reciprocal agreement. From the Canadian point-of-view, mutual recognition of the equality of each other's educational programs enables graduates to obtain the equal benefit of eligibility for licensure examinations in the other country. Canadian spokesmen emphasized that an agreement on reciprocity with respect to licensure would be outside the authority of either the Canadian Dental Association or the American Dental Association.

Dr. Mario Santangelo and Dr. Don Allen reiterated that the American Dental Association had, over a period of time, come to interpret the agreement to include licensure and had in fact actively worked to influence State licensing authorities to treat graduates of accredited programs in either country in the same fashion. They felt that the reciprocal agreement had been applied in a similar fashion in Canada up until 1979. From the ADA

point-of-view, the reciprocity agreement includes an understanding that graduates of accredited programs in either country "would be treated in exactly the same way for purposes of licensure". In the opinion of the Canadian representatives, differences in the treatment of graduates for purposes of licensure actually go back to 1971. In 1971 the NDEB agreed to certify current Canadian graduates without further examination because of its more direct involvement in and financial support of the CDA Accreditation process.

Dr. Arthur Schwartz, Chairman of the January 11th meeting at the Canadian Dental Association, assured Dr. Allen and Dr. Santangelo that the concerns they had brought to the meeting were understood. He acknowledged it was clear that ADA had indeed worked with state licensing authorities to ensure comparable treatment, for purposes of licensure, of graduates of accredited Canadian and U.S. educational programs in dentistry. He conceded that there were apparent differences in Canadian procedures for the licensure of graduates of accredited U.S. programs as distinct from accredited Canadian programs. He emphasized Canadian interest in maintaining the reciprocity agreement despite the fact that Canadian organizations co-operating in accreditation and licensure would not find it easy to introduce either of two apparent immediate solutions, further examination of all current graduates of Canadian programs or NDEB certification without further examination of all current graduates of U.S. programs. He requested time to permit full review of the problem and identification of responses.

Following the meeting of January 11th, Dr. Schwartz recommended establishment of a committee of the CDA Council on Education and Accreditation to give further consideration to the issue of the reciprocal agreement. Representation from the Council, the National Dental Examining

Board of Canada and the Association of Canadian Faculties of Dentistry would be included on the committee. The committee would be charged with completing a report on further Canadian consideration of problems related to the reciprocal agreement, to assist the CDA Council on Education and Accreditation to send a detailed reply to the American Dental Association by March 15, 1986. This date would permit the May meeting of the ADA Council on Education to discuss the Canadian response.

The Chairman of the CDA Council on Education and Accreditation, Dr. Ken Bentley, accepted Dr. Schwartz' recommendation and a committee was established with the following membership:

Dr. A. Schwartz, Chairman, (ACFD representative)

Dr. K. Bentley, (CDA representative)

Dr. H. Dick, (NDEB representative)

Dr. Gundega Kravis, Registrar, NDEB, and Mr. Brian Henderson, CDA Director of Accreditation, were asked to attend committee meetings as resource persons.

The committee first met on March 9th, 1985. The committee felt that some means of obtaining advice from appropriate segments of the Canadian Dental community was essential as the issue of reciprocity is of interest to dental educators, dental practitioners and licensing authorities. At a meeting of the committee in August a draft questionnaire was discussed and a final version agreed upon. A copy is attached as Appendix 1.

The questionnaire was distributed, to the following:

Deans, Faculties of Dentistry
Presidents & Registrars, Provincial Licensing Authorities
Presidents, CDA Corporate Members
Executive Council Members, CDA
A.C.F.D.
N.D.E.B.
C.F.D.E.
R.C.D.C.
Presidents, Specialty Sections CDA

Replies were requested by the end of November, 1985. One hundred percent of the questionnaires were completed and returned. Replies were carefully reviewed at the December 16th meeting of the CDA Committee on Reciprocity as guidance in the preparation of a brief to be sent to the ADA. This brief is accordingly based on opinions obtained from the organizations involved in the accreditation of Canadian educational programs for dentists and in certification and licensure of graduates.

Reciprocity: A Review of Developments in the United States and Canada

In 1956, the American Dental Association and the Canadian Dental Association established an agreement on reciprocal recognition of accredited programs in predoctoral dental education. In 1971, the agreement was formally extended to encompass graduate and postgraduate educational programs in dentistry. Unfortunately, the precise wording of the 1956 agreement cannot be found. The 1971 agreement on graduate and postgraduate programs, which extends the earlier agreement to include these programs, is available and reads as follows:

Resolved

that the Council on Dental Education of the American Dental Association enter into a reciprocal agreement with the Council on Education of the Canadian Dental Association for the recognition of advanced dental specialty programs in areas recognized by the American Dental Association and accredited by the Canadian Dental Association, and be it further

Resolved

that individuals who have completed successfully an advanced dental specialty program accredited by the Council on Education of the Canadian Dental Association, two or more years in length as specified by the American Dental Association, Council on Dental Education, be qualified for examination by the recognized certifying boards in the United States, and be it further

Resolved

that this agreement for reciprocity be subject to the approval of the Council on Education of the Canadian Dental Association.

Since neither ADA nor CDA has jurisdiction over the procedures and processes of licensing authorities in the various states and provinces, it is unlikely that the original 1956 agreement could have gone further than to accept graduates of accredited educational programs in either the United States or Canada as equitably prepared and eligible for the equitable benefit of being able to take licensure examinations in the other country. Correspondence (presented in

Appendix 2) from Dr. Wesley Dunn and Dr. Jean Paul Lussier verifies that this is the interpretation of the agreement on reciprocity provided by members of the Canadian Dental Association Council on Education and Accreditation who are familiar with Council activity during that period of time. Problems have arisen, however, because arrangements for licensure in the United States and Canada evolved differently in the 1970's.

Developments in the United States are conveniently summarized in "Review of ADA Licensure Policy". On Page 133 of the latter document, the following paragraph appears:

"In 1967, the Board of Trustees decided that the House of Delegates should be requested to consider establishing a licensure policy. The Council on Dental Education was asked to prepare a comprehensive statement on dental licensure for consideration by the Board and House. The position statement developed by the Council identified four principles as being in the best interest of the public and the profession: that professional licensure should be on a state basis; that all states should accept results of the national board examinations as fulfilling the written examination requirement for dental licensure; that all states should consider recognizing demonstrations of clinical competence, comparable with those sponsored by the individual state, regardless of the jurisdiction in which they are undertaken; and that all states should consider the desirability of requiring continuing education for license renewal. The Board recommended several amendments. After extensive debate on the floor of the House, the matter was recommended for further study."

The development of ADA licensure policy from that point in time is too complex to be easily summarized. The principle that all states should accept results of national board examinations as fulfilling the written examination requirement for dental licensure has slowly gained acceptance however.

In Canada, on the other hand, the National Dental Examining Board of Canada was incorporated under federal legislation on June 18, 1952. A copy of the legislation is included in Appendix 3. All provinces in Canada now license candidates who have been granted the NDEB certificate on the basis of the examination conducted by the NDEB.

A further difference in the evolution of licensure in the two countries is even more significant. The National Dental Examining Board of Canada is intimately involved in the accreditation process under which educational programs at faculties of dentistry across Canada are reviewed. The NDEB financially supports the accreditation process and has representatives on the CDA Council on Education and Accreditation. An NDEB representative is also appointed to each accreditation survey team. In addition, detailed survey reports are reviewed by all members of the Council on Education and Accreditation. By this means, the NDEB is assured that an evaluation process is in place which compares with its own evaluation process for the assessment of candidates for certification. The NDEB recognizes current graduates of accredited undergraduate dental educational programs in Canada for certification without additional examination, under section 9.01 of its By-laws;

- 9.01 "A current graduate of an undergraduate dental program in Canada which has been approved by the Council on Education and Accreditation of the Canadian Dental Association will be granted the certificate of the Board upon proper application. The Board recognizes the examinations and evaluation administered by Canadian faculties of dentistry for the purpose of certification examination.

Such a candidate must make proper application to the Board prior to March 31 in the year of his graduation. If a current graduate does not make application prior to the March 31 deadline, the candidate will fall under the provisions of By-law 9.03, that is, be required to successfully complete

- 9.01 the written examination and Parts B & C of the clinical examination in order to qualify for the certificate of the Board."

All provinces in Canada except Quebec recognize, for licensure, the NDEB certificate obtained under By-law 9.01.

Under the By-laws of the National Dental Examining Board of Canada, graduates of accredited programs in the United States are not only eligible to take NDEB examinations but need not complete Part A of the clinical examination. Graduates of Canadian educational programs who are not "current" graduates and graduates of United States educational programs are treated in exactly the same fashion:

- 9.03 A graduate of an undergraduate dental program in Canada approved by the Council on Education and Accreditation of the Canadian Dental Association or in the USA, approved by the Commission on Dental Accreditation, is eligible to take the written examination and Parts B & C of the clinical examination of the Board and if successful, will be granted the certificate of the Board, subject to By-law 9.07. If such a person is a licensed dentist, he must in addition, provide proof that he is in good standing with the provincial or state dental licensing authority."

In the United States, satisfactory performance on national board dental examinations by graduates of approved schools is accepted as fulfilling or partially fulfilling the written examination requirements in all U.S. licensing jurisdictions except Delaware. In addition each state or regional board requires successful completion of clinical examinations for licensure.

In essence, licensure in the United States is under the jurisdiction of State Licensing Boards and in Canada under Provincial Licensing Authorities. In Canada, just as in the United States, the national dental association may be able to influence but cannot control the evolution of licensure. In Canada, possibly because of the smaller number of jurisdictions, the provinces have elected to utilize the National Dental Examining Board of Canada examination process. No Licensing Authority in any province currently exercises its prerogative to conduct licensure examinations. This harmonious and efficient state of affairs, which has taken many years to achieve, assures national portability of graduates.

It is imperative that this relationship not be jeopardized. The Committee on Reciprocity reviewed various options as potential responses to concerns expressed by the ADA and sought the opinions of appropriate segments of the Canadian Dental community. The following section of the report reviews responses and reactions to each option and assesses the related implications.

Options Explored by CDA

Option 1.

CDA should encourage the possibility of the NDEB recognizing for certification, graduates of American dental education programs who have both graduated from an approved predoctoral program and who have successfully completed state licensure requirements, provided that State licensing boards would grant a license to graduates of approved Canadian predoctoral programs who have completed licensure requirements in a Canadian province.

This option was presented to be assessed as a medium term rather than an immediate solution since it would require the co-operation of several jurisdictions. The committee is of the opinion that this option would not be considered realistic by licensing authorities in either the United States or Canada.

This option was fairly strongly opposed by respondents. While a small number of respondents indicated support, their replies also acknowledged that the option was regarded as impractical.

Option 2.

CDA should encourage the NDEB to introduce a requirement that all graduates of Canadian dental educational programs be granted an NDEB certificate only upon successful completion of required NDEB examinations.

This option was presented as outside the jurisdiction of the Canadian Dental Association and it was suggested that it be assessed as a medium term rather than an immediate solution. It was also noted that the committee considers it unattractive to either the National Dental Examining Board of Canada or Canadian dental educators.

Twice as many respondents were opposed as favoured this option and the majority regarded the option as impractical. It was also pointed out that this in essence is already being done. The National Dental Examining Board recognizes the examination and evaluation procedures used by Canadian

Faculties of Dentistry on the basis of its participation in the accreditation process. It was further pointed out that the National Dental Examining Board of Canada, does in fact, require an examination for purposes of certification although it accepts under By-law 9.01 the evaluation procedures at accredited schools as an alternative to its own examination procedures .

The National Dental Examining Board and the Council on Education and Accreditation are currently co-operating in a pilot study on the systematic assessment during the accreditation process of clinical education and its products. The pilot process has been tested on accreditation surveys during which students were examined, not as individuals, but as random products of the clinical education process. This process will become a formal part of all future accreditation surveys and the representative of the National Dental Examining Board of Canada on the survey team will be one of the examiners involved. This will provide an additional mechanism for the NDEB to discharge its legal responsibility to ensure that clinical education and evaluation standards are comparable with those of the NDEB as applied in its own examination process.

Option 3.

CDA should encourage the introduction of the equivalent of an NDEB qualifying examination during the final evaluation process at each faculty of dentistry. An exchange of faculty examiners, under NDEB auspices, might be utilized as part of this process.

It was suggested that this arrangement would ensure that graduates of American dental education programs could be treated comparably with graduates of Canadian dental education programs, by permitting these graduates to take examinations at Canadian Faculties of Dentistry. A faculty

examiner exchange program under NDEB auspices could contribute to consistency. It was also noted that this option should be assessed as a medium term rather than an immediate solution since it would require the co-operation of several jurisdictions.

Responses were equally divided between those supporting and those opposing the option. Similarly, it was equally seen as both practical and impractical. The committee notes that the Council on Education and Accreditation previously recommended the use of external examiners at Canadian Faculties of Dentistry and a recommendation to this effect was accepted by the Board of Governors of the Canadian Dental Association. This Committee will recommend to the Council on Education and Accreditation that this option be explored further.

Option 4.

CDA should encourage the introduction of a prelicensure period of supervised clinical experience for graduates of an approved program (with an associated evaluation mechanism administered by the program and acceptable to the NDEB). Graduates of an approved American dental education program would be eligible for admission to the prelicensure period, and subsequent evaluation and licensure, on the same basis as graduates of Canadian dental education programs.

This option was presented as a long term solution which could provide for identical treatment of American and Canadian graduates. It was also noted that it would require the co-operation of several jurisdictions. Many respondents found this option difficult to assess and indicated that they were unable to provide an opinion. In general, the option was equally supported and opposed with the majority viewing the option as impractical.

The Canadian Dental Association, the National Dental Examining Board and the Canadian Fund for Dental Education jointly sponsored a conference on the concept of a prelicensure period in dental education at the Chateau Champlain Hotel in Montreal on February 24th and 25th, 1986. This conference resulted in the following recommendations:

- (a) That the Council on Education and Accreditation and the Council on Hospital Services of the Canadian Dental Association, the National Dental Examining Board, and the Association of Canadian Faculties of dentistry, in association with provincial licensing authorities, explore further the matter of prelicensure as part of an effort to review the entire dental education experience.
- (b) That governments, national and provincial authorities be encouraged to extend practice residency programs, and also support a review and evaluation of the delivery of dental care to federal and provincial institutions.
- (c) That the licensing bodies investigate interprovincial and/or national implications of prelicensure.

The committee studying reciprocity intends to recommend to the Council on Education and Accreditation that the further exploration of the concept of a mandatory prelicensure period include consideration of any advantages and disadvantages with respect to reciprocity.

Option 5.

CDA should encourage the NDEB to grant a certificate to all current graduates of approved American dental education programs without examination.

It was recognized that this option is outside the jurisdiction of the Canadian Dental Association and must also be assessed as a long term rather than an immediate solution. The committee feels that it is unlikely to be acceptable to either the provincial licensing authorities or the NDEB.

This option was the most strongly opposed of any presented, by a margin of six to one. By a margin of four to one, the respondents indicated that they found the option impractical and not feasible.

Option 6.

CDA should attempt to secure agreement with ADA that reciprocity is mutual recognition of each other's processes of education/accreditation. This implies an equivalent educational base which justifies an equal benefit for graduates of approved programs in Canada or the United States - eligibility for examinations for licensure in the other country without repeating elements of the educational program.

The Committee feels that this option employs a definition of reciprocity that is consistent with the jurisdictions of the ADA and the CDA. It is acknowledged that American representatives have indicated that it is likely that the ADA will see any value to reciprocity unless it extends to comparable treatment of graduates for the purposes of licensure.

Of all of the options presented, this was the most strongly supported, by a margin of over five to one. Similarly the option was regarded as highly practical and feasible. There were many comments to the effect that reciprocity with regard to the accreditation of educational programs seems to be established and should be continued and that, at the very least, recognition of each other's processes of accreditation should ensure that candidates do not have to undertake additional educational requirements, for purposes of licensure, in either country.

ANALYSIS

There is a great deal of support in the Canadian dental community for the maintenance of an agreement on reciprocity. There is also a great deal of concern about asking the National Dental Examining Board of Canada to cease to recognize evaluation processes at accredited Canadian Faculties of Dentistry when its representatives are satisfied that they employ comparable standards to those used in the NDEB examination process. There is also strong opposition to automatically granting an NDEB certificate to all graduates of accredited programs in the United States as the NDEB is not directly involved in the review of program standards and cannot discharge its responsibility, under federal legislation, to assess against a national standard.

Equally important, it is felt that the basis of a continuing agreement on reciprocity must acknowledge the complexity, if not the impossibility, of requiring that graduates of accredited programs in either country must be treated in exactly the same fashion for purposes of licensure.

Certification by the National Dental Examining Board of Canada is only one of the requirements for licensure in any province. Provinces may specify requirements related to language, length of term of license or other considerations unique to their jurisdiction. In Quebec, for example, requirements for licensure include demonstration of the ability to communicate in French. In all provinces, graduates of a program in the province are granted a license without the NDEB certificate, irrespective of their primary place of residency or citizenship.

After reviewing all of the responses to the questionnaire on reciprocity, the committee has concluded that a formal agreement on reciprocity is necessary because of differences in interpretation and because the original agreement cannot be found. This new agreement should be stated in terms that recognize the complexities involved and encourage a core consistency while also providing for differences in the development or evolution of state/provincial and national licensing processes and procedures. The final section of this brief presents a proposal which is meant to realize these goals. It is based upon the assumption that graduation from an accredited program in either Canada or the United States provides a basis for recognizing a candidate as eligible for licensure examinations or procedures without the need to repeat elements of an educational program. Comparable standards of accreditation in both countries can continue to ensure that the educational programs in both countries are equivalent and that graduates of an approved program are able to demonstrate successfully their individual ability in licensure processes and examinations in the other country.

PROPOSAL FOR AN AGREEMENT ON RECIPROCITY

The following resolutions, modelled upon the 1971 ADA/CDA reciprocal agreement on graduate and postgraduate programs are suggested for the consideration of the ADA Council on Education and the Commission on Accreditation and the CDA Council on Education and Accreditation:

1. ADA Resolutions:

RESOLVED THAT the Council on Dental Education of the American Dental Association enter into a reciprocal agreement with the Council on Education and Accreditation of the Canadian Dental Association for the recognition of predoctoral educational programs in dentistry recognized by the American Dental Association and accredited by the Canadian Dental Association and be it further

RESOLVED THAT the Council on Dental Education of the American Dental Association encourage certifying or licensing boards in the United States to recognize individuals who have completed successfully a predoctoral educational program accredited by the Council on Education and Accreditation of the Canadian Dental Association, of four or more years in length as specified by the American Dental Association, Council on Dental Education, as eligible for examination for certification or licensure without further educational requirement and be it further

RESOLVED THAT this agreement on reciprocity be subject to the approval of the Council on Education and Accreditation of the Canadian Dental Association.

2. CDA Resolutions:

RESOLVED THAT the Council on Education and Accreditation of the Canadian Dental Association enter into a reciprocal agreement with the Council on Education of the American Dental Association for the recognition of predoctoral educational programs in dentistry recognized by the Canadian Dental Association and accredited by the American Dental Association, and be it further

RESOLVED THAT the Council on Education and Accreditation of the Canadian Dental Association encourage certifying and licensing boards in Canada to recognize individuals who have completed successfully a predoctoral educational program accredited by the Council on Education of the American Dental Association, of four or more years in length as specified by the Canadian Dental Association Council on Education and Accreditation, as eligible for examination for certification or licensure without further educational requirement and be it further

RESOLVED THAT this agreement on reciprocity be subject to the approval of the Council on Education of the American Dental Association.

CONCLUSION

An excellent relationship exists between the Canadian Dental Association and the American Dental Association and CDA is committed to nurturing and protecting this relationship. The Canadian dental community and Canadian dental education benefit greatly from the experience, resources, advice and friendship of the American Dental Association. The many ways we benefit cannot help but become evident in preparing a response to concerns expressed by ADA about differences in the treatment of graduates of American and Canadian programs for purposes of licensure. Our strong and overriding objective, despite the fact that our response may fail to meet all concerns expressed by ADA, is to find a way, within our power, to continue this relationship and the reciprocal agreement which symbolizes it.

We are actively pursuing a number of initiatives, potentially related to reciprocity in one fashion or another. Among these are the following:

1. The exploration of the potential of a mandatory period of supervised clinical experience following completion of educational requirements and prior to the granting of a license.
2. The potential introduction of a system of external examiners under NDEB auspices, during final evaluation procedures at Canadian Faculties of Dentistry.
3. The introduction of a systematic evaluation of randomly selected student clinicians (and examination of patients in their care) as part of the accreditation survey of clinical education and its products.

From the analysis of responses to the reciprocity survey, it is apparent that these initiatives may or may not lead to changes in Canadian processes which might permit arrangements for licensure to allow graduates of both American and Canadian educational programs to be treated identically for purposes of licensure. We feel that the initiatives indicate both the depth of our scrutiny and the current need for a simplified agreement on reciprocity which can carry us into a rapidly changing future.

CDA Mar., 1986.

COUNCIL ON ETHICS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. G.R. Thordarson, British Columbia - Chairman
 Dr. W.G. Leggett, Ontario
 Dr. M.A. Lasko, Manitoba
 Dr. B.G. Saik, Alberta
 Dr. G.G. Turner, Nova Scotia

 Dr. E.F. Allison, Alberta - Executive Liaison

1. Council Meeting

Since the 1984 meeting of the CDA Board of Governors, Council has met once, that being on Monday, September 30, 1985 in Ottawa.

ITEMS REQUIRING BOARD ACTION

2. Guidelines concerning Newsletters

Guidelines concerning Newsletters were reviewed and approved.

RESOLVED:

86.21 THAT the appended Guidelines concerning Newsletters be approved as a resource document to be used by the provinces as they deem to be appropriate according to their circumstances.

APPENDIX I

DEFEATED

DIRECTION: That these Guidelines be left to the licensing bodies.

3. Guidelines Concerning Signs

Council reviewed and modified Guidelines concerning signs. It was noted that the guidelines regarding signs should be considered in a very general way and it is understood that many provinces have their own By-Laws or

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Codes of Ethics in which signage is considered. However, the guidelines may be useful for those provinces where no guidelines exist, or where no provision is present in either the Code of Ethics or By-Laws relevant to the control of signage.

RESOLVED:

- 86.22 THAT the appended Guidelines concerning Signs be approved for use by the provinces as they see fit in their particular circumstances.

APPENDIX II

DEFEATED

DIRECTION: That these Guidelines be left to the licensing bodies.

4. Statement re Unproven Treatment Methods

As requested by the CDA Board of Governors in September 1984, Council reviewed the draft Statement re Unproven Treatment Methods.

RESOLVED:

- 86.23 THAT the appended Statement on Unproven Treatment Methods be approved.

APPENDIX III

DEFEATED

DIRECTION: That the Statement be submitted for legal opinion.

ITEMS OF INFORMATION - NOT REQUIRING BOARD ACTION

5. Prosecutions With Regard to Ethical Matters

Council has requested Licensing Boards to provide information concerning their prosecutions with regard to ethical matters.

COUNCIL ON ETHICS

Only limited details are available to date with the main activity involving charges laid for improper billing. Advertising, however, is seen as a major issue in a number of provinces where prosecutions are currently in progress or being considered.

Council agreed that additional information would be collected with regard to specific prosecutions on ethical issues. Information available, such as legal research on topics of an ethical nature, will be identified and forwarded to the CDA resource library for use by other provinces considering a similar area of discipline. Also, brief reports on discipline hearings involving ethical matters will be identified along with the appropriate By-Law or Code used in the province where the charge was laid and these will also be made available to the CDA resource library for use by other provinces. Examples of useful information would include:

- a) legal opinions obtained on various topics
- b) alternatives to discipline procedures
- c) the signing of a card by each practitioner agreeing to abide by the Code of Ethics

6. Agreements Between Principals and Associates - Ethical Ramifications

Licensing Boards and the Provincial Associations will be asked for examples of specific issues where arguments had occurred between dentists. Once this material is acquired, it will be put together as a report for the use of the provinces. It was also suggested that perhaps a "model agreement" could be considered, although opinion varied as to the usefulness of this as each agreement should be arrived at with the practitioner's specific requirements being met. Further discussion will be required.

7. Unethical Conduct

Council discussed the potential for unethical conduct of dentists and dental auxiliaries and specialists vis a vis the referral of patients, management of extensive cases, etc. Additional information and opinion will be gathered and guidelines produced on this topic for consideration at the next Council meeting.

8. Guidelines for the Use of Dental Indemnity Insurance

Council reviewed and amended a draft document entitled Guidelines for the Use of Dental Indemnity Insurance. The revised draft will be circulated to Council and also to members of the Board of Governors and the Licensing and Membership organizations for comment prior to producing a final draft.

APPENDIX IV

The document is then to be forwarded to the Board of Governors for their consideration as guidelines to be used by the provinces as they deem to be appropriate according to their circumstances.

9. Fee Schedules

Correspondence was reviewed from a dentist concerned with regard to the ethical conflicts involved with usual and customary fee schedules of practitioners versus government imposed fee schedules for certain classes of patients. Council concluded that since provincial Dental Acts allow for a schedule of fees to be negotiated by provincial organizations with government or similar agencies on behalf of the dental profession, that no conflict would exist where a practitioner charged less than or more than his usual and customary fee under such a negotiated fee schedule.

10. Correspondence had been received with regard to the ethical ramifications of listing of dentists by name and perhaps with comment respecting attendance at continuing education courses. This was often part of promotional material being mailed relevant to continuing education courses. Council's opinion was that such listing of names was not professional advertising and was not an ethical conflict and that these testimonials merely represented the opinion of those dentists.

11. Ethical Implications/Capitation & Other Third Party Issues

Council has received a request from the Council on Health Care for comment on possible ethical implications of various alternate delivery systems. Additional information is required, and this item will be discussed further at the next meeting of Council.

Respectfully submitted,

G.R. Thordarson, D.M.D., F.I.C.D.
Chairman
Council on Ethics

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Ethics with appreciation.

NEWSLETTERS

The advent and utilization of patient newsletters can be a method of providing worthwhile information to the patients of a dental office. Such a newsletter could include:

- a) News about recent developments in dental science and treatment procedures. Where the information being provided is not established fact of established practice but represents an opinion, this should be stated.
- b) Dental health education articles.
- c) Historical "tit-bits" about dentistry.
- d) Nutritional information (as it relates to dental health) and sugarless recipes.
- e) Personal information with regard to staff and dentists, etc.

Any such information offered is considered a reflection of the professional opinion of the dentist(s) issuing the letter, and therefore completeness and appropriateness of all articles should be carefully reviewed, prior to distribution. In addition, since the information provided is of necessity incomplete or in a very short form, patients should be informed of this shortcoming and encouraged to ask for more complete information from the dentist or his/her staff.

There should not be:

- a) Any material or statements that could be considered as flamboyant, self-laudatory, or self-aggrandizing.
- b) Statements which imply more skill, knowledge, care or courtesy than offered in any other dental office.
- c) Statements that a certain office enjoys superior facilities.

For example, "latest modern equipment" or "modern methods" or "quality dentistry".
- d) Claims of "new", "unique", or "painless" methods of delivery.

Newsletter distribution is to allow communication only with current "patients of record" of the office. In-office distribution is acceptable. It is not considered appropriate to encourage newsletters to be forwarded on to secondary persons, or to allow for other distribution methods to occur, such as out-of-office distribution techniques, so that members of the public who are not patients of record have access to the newsletter.

The content and distribution of newsletters is at all times governed by the current Code of Ethics and the Rules and By-laws of the licensing body.

The licensing body suggests that any dentist preparing a newsletter submit it to the Registrar's office for review and possible comment which may avoid disputes concerning the propriety of various statements occurring after distribution of the newsletter.

GUIDELINES CONCERNING SIGNS

By-law 87A of the licensing body, section (f) (VI) describes the permitted signs that may be utilized by a member on the premises where the member practises. This section reads as follows:

"(vi) not more than two exterior signs stating a member's name and his vocational designation, on the premises where the Member practises but,

- A. only one sign may be a suspended sign,
- B. only one sign may be illuminated and shall not be of an intermittent or neon type,
- C. the letters used in a sign shall not exceed ten centimeters in height,
- D. words designating office hours may be added to an entrance sign in unilluminated letters not more than five centimeters in height,
- E. where an entrance is difficult to find, the words "entrance on" may be added to the sign."

Over the past two years, some of our members have commenced practice in shopping malls, department stores and other locations which require, sometimes by contract, a different format of sign, one that is in keeping with the surroundings in which it is to be placed.

The Ethics Committee has considered various types of signs and agrees that they should be in keeping with their surroundings which may, on occasion, result in a deviation from the By-laws and Code of Ethics as stated above.

The Ethics Committee therefore feels that it is acceptable to consider a sign that fits with the signs that are on adjacent premises in a shopping mall or other similar location. This may require that the letters be larger than the recommended ten centimeters in height and other elements of style or content may be accepted as reasonable given certain circumstances.

The Ethics Committee continues to feel that the sign should be in keeping with the dignity of the profession. It becomes obvious when reviewing signs in various shopping malls that some tend to be more garish than others and certainly a dental office should be conservative in their approach to such signage.

Under no circumstances should the dental office be dictated to by the owner of the mall. A sign that will not conform to the By-laws and Code of Ethics should be brought to the attention of the licensing body via the Registrar before it is made up. That is, any member who is faced with some special problem or circumstance which might warrant a variance of any standard set out in the sections of the Code or the By-laws relevant to signage may

appeal to the Council of the licensing body, the Executive Committee or its delegate, who may grant a variation to the Code or By-laws as circumstances may dictate. This variance may include the size of the sign in total, the size of the lettering, the illumination, the contents of the sign, its relationship to the signage in the immediate area, and other details as required.

The use of logos in reference to dental practices on letterhead, business cards and on occasion, signs, appears to be increasing in popularity. Logos are not permitted under By-law 87A. Where a logo is being considered, permission for its use must be applied for and granted by the Council, Executive Committee or its delegate, as must all deviations from By-law 87A. Logos being considered should be tasteful and dignified as befits a health profession. The logos should not be substantially larger than the letters or increase the size of the sign but should, if they are to be used, blend in with the sign indicating the dental office name. Only logos that are drafted and planned in such a manner will be considered for approval.

STATEMENT RE UNPROVEN TREATMENT METHODS

Treatment methods utilized by dentists in the management of patients which have not been verified by sound scientific evidence should only be used with the patient's informed consent, in writing. This consent would recognize the probabilities of success and the potential complications of such treatment. Such methods of treatment should only be used after other accepted treatment modalities have been assessed and found to be unsuitable.

5. Other Council Initiatives

The Council on Health Care has also been developing a number of other resources of interest to members of the profession. In order to ensure that guidelines and resources finally presented for approval have benefitted from the widest possible input, the Council on Health Care is making draft documentation available for comment and advice while the documents are still under development. In addition to the draft of a standard referral form which will be circulated separately, the following documents are being reviewed:

1. Proposed Recommendations for the Dental Treatment of AIDS Patients.
2. Proposed CDA Guidelines on Conscious Sedation.
3. Proposed CDA Policy Statement on Sugar in Medications.

Comments and suggested revisions should be directed to Mr. Brian Henderson before May 1st, 1986.

I believe that this progress report illustrates that the Council on Health Care is working effectively within its new structure and look forward to presenting the above documents, revised with your guidance, for the approval of the CDA Board of Governors at the 1986 Annual Meeting.

Respectfully submitted

Andrew Toeman,
Chairman,
Council on Health Care.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Health Care with appreciation.

APPENDIX I

CDA and DENTAL IDENTIFICATION SYSTEMS

A DISCUSSION PAPER

BACKGROUND:

At the November meeting of the CDA Council on Health Care, Council approved a resolution in support of systematic denture marking for identification purposes. The wider question of whether the Canadian Dental Association should take a position on using human teeth as the location for identification discs was referred to the Executive Sub-Committee of Health Council. It was recognized that some public demand for dental identification systems exists, that a Canadian system, developed by Dr. Phil Samis, is gaining international acceptance and that the public interest can be served by some such permanent identification system because of factors including the large number of children abducted annually and the need to identify accident victims, etc. Council expressed some initial concerns about using invasive procedures on healthy teeth, even with patient consent. It was noted that Dr. Samis' system offered non-invasive alternatives as a matter of choice.

EXECUTIVE SUB-COMMITTEE ACTION:

The Executive Sub-Committee has decided that the question of Dental Identification Systems and CDA initiatives deserves further consideration by Council. It appears that dental identification systems will develop, in response to perceived need, with or without national recognition and co-ordination. The American Dental Association has become involved at the national level in the United States (See attached). The Canadian Dental Association may be able to play a similar national role and has the advantage of the existence of a Canadian dental identification system, developed by Dr. Samis, which is currently available and already well-established. The Executive Sub-Committee of Council accordingly asks Council to consider the following questions, in the order listed.

Questions for Discussion

1. Should the Canadian Dental Association take a position on the use of dental identification systems (or on the conditions under which dental identification systems are regarded as acceptable).

ELABORATION: Should CDA support or not support the use of such systems? Are there conditions with respect to types of system, impact on the healthy tooth or other qualifying concerns that CDA should state for public guidance.

2. If so, should CDA take a position on the kind of identification system (marking system) to be employed on the identification disks? What method of marking is recommended?
3. Should CDA publically identify those systems it regards as professionally acceptable (i.e. meeting any identified conditions or qualifying concerns).

ELABORATION: CDA already grants public recognition to tooth pastes with fluoride. Should it provide public recognition for ID systems with potential impact on the teeth?

4. Should CDA become involved in any operation or facet of a national dental identification process, such as:
 - maintenance of a national registry and phone line
 - promotion, distribution or sale of approved systems/supplies?

BJH:dh

Health Care
Jan. 16, 1986

Microdisk readied for distribution Maryland site of test market in February

Chicago—The Association's American Dental Identification Registry (ADIR) is scheduled to debut in February, following a public announcement at the ADA annual session in San Francisco.

Meeting at Headquarters Oct 24-25, the ADA Council on Dental Practice approved final plans for the ADIR, the Association-developed permanent identification system.

"This is not a missing children's program, but rather a national identification system that will benefit the elderly, handicapped, and frequent travelers as well as children," said Dr. French Moore, Jr., council chairman.

Maryland was selected as the first site of distribution for the ADIR in February because it represents a small geographic area but is convenient to major media centers, Dr. Moore said. The Maryland State Dental Association displayed "great enthusiasm" for the project and had aggressively pursued the option for the state to be the test market site, he added. The system is expected to be available nationwide by April.

The ADIR is a system of permanent identification in which a tiny microfilm disk bonded to a tooth is coded to correspond with information kept on file about that person at the Association. The microdisk will be sold under the trade name of ADIR DataDisk.

The microdisk is a circular cutout—about 2.5 mm in diameter—of polyester-based photographic film. The microfilm is laminated on its emulsion side with a protective layer of mylar/polyethylene composite material.

Each disk will carry a unique patient identification number, a national telephone number, a telephone receiver symbol, and the ADA logo. The ADIR registry at Headquarters will contain a computerized record of basic identifying information to correspond with each disk, including the patient's name, address, telephone number, Social

Security number, sex, and the name of the treating dentist. The registry will not include medical alert information.

Plans call for the microdisks to be sold in sequentially numbered packages of ten. The microdisks will be made available through the Association's order department to licensed dentists and recognized related organizations. The cost to ADA members will be \$10 per microdisk; nonmembers will be charged \$12.50.

The council recommends a standardized location for placement of the microdisk: on the buccal surface of the maxillary right first molar in adults and the equivalent surface of the most posterior primary molar in children. The disk is to be bonded to the tooth surface with commercially available composite resins. The simple procedure is estimated to take about 10 minutes and involves no drilling or anesthesia. Information on the disk is readable under simple magnification; and the disk need not be removed for reading.



ADIR microdisk

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

MEMBERS: Dr. J. H. Gryfe, Chairman, Weston
Dr. C. Foster, Manitoba,
Dr. J. Hardie, Ontario
Dr. V. Legault, Quebec
Dr. E. L. MacInnis, Nova Scotia
Dr. W. S. Walter, British Columbia

Dr. J. W. Niedermayer, Executive Liaison, Saskatchewan

1. Council Meetings

The Council has met once since the last report to the CDA Board of Governors, on January 17 & 18, 1986 in Ottawa.

2. All members were in attendance at this meeting. Also present for the entire proceedings were the Director of Accreditation and the Executive Liaison, Dr. Jack Niedermayer. Dr. Gary MacDonald of Mount Pearl, Newfoundland was an invited guest on January 18th representing the Medical & Health Care Advisory Committee, Correctional Services Canada.

3. ITEMS REQUIRING BOARD ACTION

RESOLVED:

- 86.26 WHEREAS the necessity for standardization of appropriate categories of accreditation for both the purposes of the Council on Education and Accreditation and the Council on Hospital and Institutional Services is recognized,

THAT the "Accreditation Eligible" category be added to the list of categories for accreditation of hospital and/or institutional services.

ADOPTED

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

RESOLVED:

- 86.27** WHEREAS the Joint Advisory Committee on Accreditation document entitled "Confidentiality and Disclosure of Information in the Accreditation Process" (appended to this report as Appendix 1) has been approved by this Council and forwarded to the Council on Education and Accreditation for similar approval,

APPENDIX

THAT subject to approval of this document by the Council on Education and Accreditation it be accepted as the policy of the Canadian Dental Association

ADOPTED

RESOLVED:

- 86.28** WHEREAS the Canadian Dental Association through the Council on Hospital and Institutional Services has played an active role in endeavouring to minimize potential adverse impact on the delivery of dental care created by the Canada Health Act and

WHEREAS it is felt that provincial negotiation should be encouraged by the local dental associations and

WHEREAS it is felt that these local negotiations may be more effective with an understanding of the CDA's actions and policies in this regard,

THAT a statement in this regard attached to this report as Appendix 2 be accepted as a statement of the Canadian Dental Association policy.

APPENDIX

ADOPTED

COUNCIL ON HOSPITAL AND INSTITUTIONAL SERVICES

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

4. Through the Director of Accreditation the Council expressed its sincere appreciation for the extraordinary co-operation extended to the Canadian Dental Association by the Order of Dentists of Quebec during the recent combined, integrated survey at McGill University's Faculty of Dentistry and related hospital services.

Executive Council expresses its gratitude to the Order of Dentists of Quebec for their service in assisting in the accreditation process.

5. A letter has been forwarded to the Canadian Council on Hospital Accreditation supporting their stand on the inadmissibility as evidence under the Canada Evidence Act, of any documents or personnel participating in peer review or medical audit/patient care appraisal processes in hospitals.

6. Dr. Gary MacDonald of Mount Pearl, Newfoundland the dental representative to the Medical and Health Care Advisory Committee of the Correctional Services Canada reported to the Council on this Committee's activities. This report is appended as Appendix 3. Council acknowledges Dr. MacDonald's co-operation and dedication on behalf of dentistry and appreciated his ongoing liaison with the Canadian Dental Association.

APPENDIX 3

Executive Council expresses its gratitude to Dr. Gary MacDonald for his activity on behalf of the Association and for the quality of his Report.

7. Council acknowledges with sincere appreciation the continuous assistance and unceasing efforts of the Director of Accreditation, Mr. Brian Henderson.
8. The Council wishes to thank Mrs. Lorraine Emmerson for her ongoing efforts.

Respectfully submitted

Dr. J. H. Gryfe,
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Hospital and Institutional Services with appreciation.

CONFIDENTIALITY AND DISCLOSURE OF INFORMATION IN THE
ACCREDITATION PROCESS

DEFINITION OF ACCREDITATION

Accreditation is simply a process which measures institutions, specific services or educational programs against a predetermined national standard.

DISCLOSURE AND CONFIDENTIALITY

Dentally-related educational programs or institutional dental services may respectively seek accreditation through the CDA Council on Education and Accreditation or the CDA Council on Hospital and Institutional Services. When accreditation is sought, the educational program or dental service voluntarily supplies a large amount of information to the accreditation process. Such information is provided to permit the accreditation process to assess compliance of the program or service with detailed national standards. It is understood and expected that the particular CDA Council which reviews the resulting accreditation report, the Director of Accreditation and association staff and the survey team which prepares the report will maintain full confidentiality with respect to information submitted or obtained during the on-site review and subsequent discussion.

The ability of the accreditation process to assess programs or services (and in so doing encourage their continuing development and enhancement) is dependent upon the voluntary disclosure of pertinent information. Voluntary disclosure, in turn, is dependent upon demonstrated respect for the principle of confidentiality within the accreditation process.

THE PUBLIC INTEREST AND DISCLOSURE

Accreditation, by definition, provides an assessment of quality for the information and guidance of the public. If it is to be taken seriously, the accreditation process in all of its facets -- structure, policies and processes -- must demonstrate its worthiness to provide such a public service. It must be clear and apparent that the process is not quietly serving the selfish interests of a specific group. The structure of the accrediting agency and its policies and procedures must reflect both the appropriate expertise and the necessary objectivity and integrity to render credible judgement, on the quality of programs or services. The judgements must be made available to the public even though the detailed basis for the judgements must not be released unilaterally by the accrediting agency.

The product of the accreditation process is a decision to award (or withhold) an accredited status. Categories of accreditation status within the CDA accreditation process are as follows:

ACCREDITATION ELIGIBLE

On the basis of a limited site visit evaluation and/or an institutionally prepared prospectus the proposed educational program or dental service appears to meet the minimum requirements for APPROVAL as established by the Council on Education & Accreditation or the Council on Hospital and Institutional Services.

PRELIMINARY APPROVAL

(Council on Education & Accreditation only)

On the basis of a limited site visit and/or an institutionally prepared prospectus the educational program is granted year by year PRELIMINARY APPROVAL if it continues to appear to meet the minimum requirements for approval as established by the Council on Education and Accreditation after initial enrolment of students and until such time as students are enrolled in the final year.

PRELIMINARY APPROVAL AND ACCREDITATION ELIGIBLE are granted to provide evidence to prospective students, educational institutions, licensing bodies, governments, granting agencies, etc., that at the time of evaluation a developing program or dental service meets standards set forth in the Minimum Requirements for Approval of the specific program.

PROVISIONAL APPROVAL

On the basis of a site visit and an institutionally prepared prospectus this classification is granted to an educational program or dental service if it has been determined that the program or service has deficiencies or weaknesses in one or more specific areas. This accreditation classification signifies the seriousness of the deficiencies or weaknesses but is considered adequate to meet the eligibility requirements for licensure and board examinations in the case

PROVISIONAL APPROVAL (Cont'd.)

of educational programs, or to maintain adequate standards of patient care in dental services. The deficiencies or weaknesses are considered to be of such magnitude that, if not corrected withdrawal of the program's or dental service's accreditation status will result. Evidence of significant progress in order to maintain the status of approval must be demonstrated within one year.

CONDITIONAL APPROVAL

On the basis of a site visit and an institutionally prepared prospectus this classification is granted to an educational program or dental service where specific deficiencies or weaknesses exist in one or more basic areas of the program or service. The deficiencies or weaknesses are considered to be of such a nature that they can be corrected in a reasonable length of time, which is ordinarily defined as a period not to exceed two years. This accreditation classification is considered adequate to meet the eligibility requirements for licensure and board examinations in the case of educational programs or to maintain adequate standards of patient care in dental services. An institution receiving the status of **CONDITIONAL APPROVAL** must provide a progress report at the end of the first year.

FULL APPROVAL

On the basis of a site visit and an institutionally prepared prospectus this classification, when granted to an educational program or dental service, indicates that the program achieves or exceeds the minimum requirements for **APPROVAL** as established by the Council on Education and Accreditation or the Council on Hospital and Institutional Services, respectively. This accreditation classification indicates that the program has no serious deficiencies or weaknesses. However, recommendations or suggestions relating to enhancement of the program or dental service are generally included in the evaluation report.

The names of programs or services which have gained an accredited status are published annually and information on accreditation awards is available to the public on request. Information available is restricted to the name of the program or service and the category of accreditation award. A policy of full disclosure, however, governs information about the overall CDA accreditation process and its structure, policies and standards.

SURVEY REPORT

The policy regarding disclosure and confidentiality of actual accreditation survey reports is necessarily more complex. Institutions may wish to release portions of a survey report to appropriate individuals within the institution, on a selective basis. As noted, the accrediting agency must not publically release an accreditation report unilaterally. On the other hand, if a dental education program or dental service releases selected portions of an accreditation survey report — beyond the immediate program or service — false impressions may be created. The accrediting agency then has the right to release the complete accreditation survey report. The policy of the Canadian Dental Association with respect to release of accreditation survey reports may be summarized as follows:

- (1) Educational programs or dental services may distribute or release complete copies of their own CDA accreditation survey reports as they see fit. Dentally-related educational programs are encouraged to send a copy of the accreditation survey report to the registrar of the provincial licensing authority.
- (2) Educational programs or dental services may distribute or release relevant selected portions of their own accreditation survey report to appropriate centres within their institutions.
- (3) The Canadian Dental Association will not unilaterally release an accreditation survey report to the public unless it is judged necessary to protect the accreditation process when portions of a specific accreditation survey report have been released by the program or service to the wider professional community or public (beyond the institution immediately concerned with the educational program or service).
- (4) Within the Canadian Dental Association, accreditation survey reports shall be treated as confidential documents and limited in distribution to the members of the specific survey team, the Director of Accreditation and associated staff and the CDA Council on Hospital and Institutional Services or the CDA Council on Education and Accreditation.

Revised Jan. 1986

DRAFT SUMMARY OF POLICY ON THE CANADA HEALTH ACT

The Canadian Dental Association has consistently endeavoured to minimize potential adverse impact on dental care created by the introduction of the Canada Health Act.

Prior to the CHA's legislative approval, CDA was successful in securing an amendment to the draft legislation removing federal regulations which would have created problems for existing provincial dental service. When the Act became law, CDA informed the federal Minister of Health and Welfare that it was being misinterpreted at the provincial level, both by government and third party insurers. The misinterpretation is resulting in dentists not receiving payment for all services provided. While the Minister responded positively by raising the concern of a federal-provincial health ministers' meeting, problems continue to exist.

The Canadian Dental Association subsequently formally expressed its support for the Canadian Medical Association's legal challenge to the Canada Health Act as federal legislation governing an area the Canadian Constitution specifically recognizes as within provincial jurisdiction. CDA believes that immediate legal clarification is urgently needed in the interests of both patients and health professionals.

CDA recognizes that most dentists are not involved in the provision of medicare insured services and are consequently not directly affected by the legislation. CDA also recognizes that the public does not seem to understand the points of principle that make the Canada Health Act and provincial enabling legislation inconsistent with the traditions of a democracy.

The Canadian Dental Association, however, continues to believe that the Canada Health Act discriminates against health professionals co-operating in the provision of government insured health services because it removes their freedom to charge independently established fees by financially penalizing provinces and forcing them to introduce their own legislation establishing fines for health professionals who collect fees above those established by medicare for insured services. CDA's Council on Hospital and Institutional Dental Services is currently exploring means of assisting provincial dental associations in dealing with such legislation and resultant problems.

Jan./86
Council on Hospital & Institutional Services

REPORT TO COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES
JANUARY 18, 1986

Dr. Gary MacDonald, Medical and Health Care Advisory Committee
Correctional Services Canada

It is indeed a pleasure to have been asked to report to the Council on Hospital and Institutional Services. I don't know how much you know about the Medical Health Care Advisory Committee but I do know if it's no more than I knew this time last year — you know very little.

I would like to give you a brief history of the committee, its make-up and general mandate — but most importantly give you some idea of the scope of dental services being provided in the federal institutions.

In February 1985 I received a telephone call from Dr. John Robertson asking me if I would be interested in accepting a nomination from the Canadian Dental Association to serve as a member of the Medical and Health Care Advisory Committee to Correctional Services Canada. Now that was a mouthful, and when I questioned John as to what that entailed, he reply was: "We're not sure; I'll see if I can gather more information." However, I told him I was definitely interested and would accept the nomination. I attended my first meeting of the Committee less than one month after Dr. Robertson's phone call — I was listed in the Minutes as a guest, and on April 3rd I received my official appointment by the Commissioner, Rheal LeBlanc.

My predecessor, Dr. John Callingham of Ottawa had served on the original National Health Services Advisory Committee, which was formed in 1973 to advise Correctional Services Canada (CSC) on the complete upgrading of the provision of health services to the inmates in our Federal Prisons. As a result, two reports were published — the first in 1974 and the second to follow one year later in 1975. A total of 124 recommendations were brought forward in the two reports, dealing with the roles and responsibilities of the Medical and Health Care Services Branch, and of physicians, dentists and nurses in the Penitentiary Services, that would insure inmates with access to health care and medical, psychiatric and dental treatment of a quality consistent with currently accepted Canadian practices and standards.

Most of these recommendations have been instituted, and health care centres in most institutions provide comprehensive medical-surgical, psychiatric, dental, nursing, laboratory, radiology and rehabilitation therapy services to all inmates in need. Regional Psychiatric Centres are also available for mentally ill inmates.

In 1977, the present Medical and Health Care Advisory Committee was organized. This brought in the Psychiatric group which previously had an advisory Committee giving assistance only in its own field of medicine.

2.

The Committee is composed of eight members representing various associations. These members are:

Dr. Bill Ibbott, Chairman representing CMA
Dr. Noel Garneau, representing the Canadian Psychiatric Association
Miss Shirley Smale, representing the Canadian Nurses Association
Dr. Ken Wylie, representing the Canadian Medical Association
Dr. Donald Rice, representing the College of Family Physicians of Canada
Dr. Selwyn Smith, representing the Canadian Psychiatric Association
Dr. Gary MacDonald, representing Canadian dentistry

There is presently one vacancy from the Canadian Medical Association.

Members of the Committee are appointed by the Ministry from nominees of these various associations but do NOT directly represent the various associations.

Dr. Dan Craigen, Director General of the Medical and Health Care Advisory Committee is an ex-officio member of the Committee and he oversees the administrative details.

CDA's Council on Hospital and Institutional Services has maintained an interest in this Advisory Committee as part of its general mandate, and as a means of maintaining communication with this Council, I forward a copy of minutes of meetings to your Council Chairman, Dr. Gryfe. We feel it is important that the CDA Executive Council and the Board be kept up-to-date by communication through your Council.

If you will bear with me I think it would be appropriate to give you the Terms of Reference of the Medical and Health Care Advisory Committee.

1. To follow up and advise on the implementation of the recommendations contained in the first and second reports of the National Health Services Advisory Committee, as well as subsequent recommendations of the Medical and Health Care Advisory Committee.
2. To help maintain liaison with appropriate professional bodies and colleges.
3. To study and advise on the existing and proposed health care systems (i.e. medical records, drug control) and to make recommendations for the development of appropriate systems.

3.

4. To advise and make recommendations with regard to the development and implementation of standards for medical and health care services.
5. To study and make recommendations regarding policy and policy implementation in relation to medical and health care services.
6. To advise and make recommendations with regard to the development of a monitoring and evaluative process for medical and health care services.
7. To advise and recommend additions, amendments, or guidelines for ethical professional conduct.
8. To undertake such other matters that are required of the committee, including on-site visits to institutions when deemed appropriate.

There are rumours these Terms of Reference will soon be revamped.

The Penitentiary Act and the Penitentiary Service Regulations are the legal basis for the dental services rendered to inmates, and regulation 2:16 states that: "Every inmate shall be provided with essential medical and dental care."

The Policy and Procedure Manual for Medical and Health Care Services clearly accounts for the dental care provided in the correctional institutions.

The dentist in his professional role shall diagnose and treat dental conditions, implement programs to promote oral hygiene and prevent dental deterioration, and to supervise the activities of other members of the dental team.

Emergency dental care shall be available at all times when needed for relief of pain, acute infection, haemorrhage and any dental or oral condition affecting immediate safety or comfort.

Teeth shall be restored to functional and aesthetic acceptability using standard restorative materials. If, in the clinical judgement of the dentist, restorations using gold or other precious metals are required, the dentist must prepare a request including details as to why standard materials cannot be used. This request is dealt with by the Regional Manager, Health Care Services.

Periodontal treatment shall be given when required but the inmate's motivation and responsibility in assuming good oral health care shall be a factor to be considered before periodontic treatment is undertaken.

Endodontic treatment shall be available for anterior and bicuspid teeth where it will prevent the first break in a quadrant or avoid the necessity of providing a prosthetic appliance.

Minor surgical preparation of the mouth, for insertion of dentures and surgical and adjunctive treatment of minor pathological conditions shall be performed as required in the dental clinic of the health care centre.

Removed or asymptomatic impacted or unerupted third molar teeth shall be discouraged except for the young offender serving a long period of incarceration.

Those inmates requiring outside hospitalization for health reasons shall be referred to the dental department of the local hospital.

Preventive dental care shall be provided with specific local preventive procedures prescribed by the dentist as required.

Denture wearers shall be provided with cleanser, adhesives, brushes and receptacles as necessary and, a dental record shall be completed and shall be part of the inmate's health care record.

Dental prostheses and appliances shall be provided when the health of the inmate otherwise would be affected adversely, as determined by the dentist responsible.

The need for repair or replacement of prostheses and appliances arises from three major causes: normal wear and tear, careless handling, or willful negligence.

The inmate shall assume the cost of the repair or replacement, if it is due to either of the latter two cases, regardless of whether the prosthesis or appliance was originally purchased by the inmate or the Penitentiary Service. Medical Services shall defray the cost of the repair or replacement of appliances when the dentist has evidence that the need has arisen for normal wear and tear.

Figures for 1985 indicate that 29 federal institutions have dental clinics or dental treatment areas, all equipped with a dental chair and X-ray unit and necessary equipment to provide the dental services required. In addition, three Panclipse X-ray units were purchased in 1975 for reception use in Regional Reception Centres. They are now utilized in the Regional Reception Centre in Quebec, Kingston Penitentiary and Matsqui.

C.S.C. has two public servant dentists working at the Federal Training Centre and Kingston Penitentiary. The balance of CSC is covered by 29 part-time dentists under various contractual conditions. The full-time public servants are classified at salary level two, earning \$49,492.00 and \$45,364.00 annually. The remaining part-time contract dentists hold contracts ranging from \$1,100.00 to \$64,000 annually. This varies due to the variety of services provided, various contractual arrangements whether with or without an assistant, by the hour or session, etc.

Dental hygienists have a very limited role in providing a service to C.S.C. The Regional Psychiatric Centre in the Prairies is the only institution that employs a dental hygienist at present. The contract is on an hourly basis to a maximum cost of \$6,672.00 and is provided by the University of Saskatchewan College of Dentistry. C.S.C.'s affiliation with the University is considered a factor in this arrangement. I believe the main obstacle with more widespread utilization of dental hygienists lies in lack of space and equipment coupled with the direct supervision requirement.

I asked Dr. Craigen how he would envisage co-operation or affiliation with the university dental school undergraduate and internship programs with respect to providing treatment by students to the federal institutions. His answer was "favourable, if possible", and mentioned that several years ago the University of Toronto Dental Faculty was approached with such a program in mind, but was unsuccessful in establishing a program. Dr. Craigen said he was meeting with the then CDA President, Dr. Crawford, last fall, and would discuss this; although I have heard nothing more.

With respect to accreditation of dental facilities in health care units of the federal institutions; this is something that would require considerable discussion and if decided to be a worthwhile venture, a pilot project might be instituted.

Both of the Regional Psychiatric Centres, Prairies and Pacific, are medically accredited and the availability of dental support services is a factor in their accreditation.

Penal accreditation under the USA Commission on Accreditation for Corrections has been granted for several C.S.C. institutions and again, the provision of dental care is a factor. This program has, however, been suspended for 6 to 10 months.

Dr. Craigen had informed me this subject was to be discussed at a meeting with Brian Henderson and Dr. Gryfe, and maybe Dr. Gryfe can shed more light on this subject.

Complaints and/or recommendations from dental staff and/or inmates with respect to the dental facilities and treatment provided are very minimal; which in itself says something for the quality of treatment received and the availability of dental services.

Assistant Wardens of Health Care Services have voiced some concern that possibly C.S.C. is providing more dental care than is necessary and consider it expensive - which means a large drain on their health care budget - but it should be noted that many inmates have neglected their teeth prior to incarceration due in part to their life-styles, thus precipitating more than average restorative work.

A few management reviews have revealed a high backlog of work to be done, however this is not considered to be a big problem as many people have to wait to see a dentist, although this is certainly changing.

On arrival to a federal institution, a dental examination is carried out on all inmates by the dentist as soon as an appointment is available; but always within three months of reception; to assess the inmate's oral health and to formulate an individualized treatment plan specifying the priorities of treatment.

On release or transfer, a complete record of examination is made on the dental record and is filed with the inmate's health record. I am presently assisting C.S.C. in updating the current dental record.

During the past year, I have attended three meetings of the Medical and Health Care Advisory Committee and some of the major agenda items have included.

- (a) Security in the Health Care Unit
- (b) Privatization of Services
- (c) Sex Offender Treatment Program
- (d) Role of Psychologists in the Correctional Services
- (e) Review of Mental Health Services
- (f) Acquired Immune Deficiency Syndrome
- (g) Traumatic Injuries in Federal Penitentiaries

Dentistry has not been brought up as an agenda item and consequently I had to do some searching to find answers on many of the aspects of dental services and their delivery in the prison environment. I was fortunate in October to have visited the Health Care Centres at Milhaven and Collins Bay. This gave me a first-hand view of the physical plant and some of the problems in providing quality dental care in an institutional setting.

The dentists providing these services must be commended for providing a high quality service under non-ideal and often stressful conditions. As was noted in the first report of 1974 to the Commissioner:

"In the real sense of the word, there is a 'captive' group of patients who with proper stimulation with the dental team can be motivated. This was pointed out by two young, eager dentists who felt a genuine sense of respect from the younger inmates that they treated. This feeling is what keeps these young practitioners returning and points out proof that recruiting of dentists can be more attractive in conjunction with their private practices in adjoining municipalities.

These dentists should be congratulated for their commitment and dedication to the treatment of patients in an environment not as peaceful and harmonious as most all of us are accustomed to."

7.

In closing, I want to thank the Council on Hospital and Institutional Services for inviting me to give this report. I trust that it has enlightened you a little with respect to dentistry behind the walls and to a lesser extent to my role as a member of the Medical and Health Care Advisory Committee.

I trust the lines of communication between your Council and the Advisory Committee are a two-way street. I am expected to keep you informed and I encourage any help and advice from your Council to ensure the highest quality dental care is available at our Federal Institutions.

COUNCIL ON INFORMATION SERVICES

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Council Members: Dr. Y. Kamachi, Chairman, Ontario
 Dr. R. Howaniec, B.C.
 Dr. W.T. Koltek, Manitoba
 Dr. G. Lafrenière, Québec
 Dr. C.S. LeBlanc, N.B.

Executive Liaison: Dr. E.F. Allison, Edmonton, Alberta

1. Council Meetings

Council has met twice since the last Board, on November 8, 1985, and January 31, 1986. Mr. Mark Sarner was a guest at both meetings.

Items Requiring Board Action

2. Dental Awareness Program

At the January meeting Council discussed the current status and the future of the Dental Awareness Program. Council expressed satisfaction with Manifest's performance to date. Since the last report to the Board, a number of DAP initiatives have taken place and others are currently being developed. As the momentum of DAP grows a concrete, visible level of activity is emerging:

- Public awareness will grow as a result of projects scheduled through the spring, summer and fall 1986;
- Media exposure continues to increase;
- The DHM '86 program will involve provincial corporate bodies, all CDA members and selected high-profile sponsorship projects;
- A new public service print ad campaign has been developed for launch in April. It will generate further media exposure at little cost;
- Provincial corporate bodies are accessing DAP resources to help them develop their own awareness program capabilities;
- CDA members are better informed and better served by DAP resources for in-office use;
- Research is a working tool of DAP programming.

In addition, expenditures/revenues for DAP/DHM are consistent with the two-year budget projection.

APPENDIX I

To date, CDA has obtained \$900,000 in corporate sponsorship. This translates into 225% in leverage, in terms of CDA's two-year, \$390,000 investment. It is anticipated that the return on CDA's investment should surpass the four-to-one mark by the end of year two. Negotiations currently underway on other projects could result in as much as another \$500,000 in DAP sponsorship.

A positive working relationship has developed between CDA and the corporate business sector. The investment not only of money, but of time and material resources expended by these sponsors clearly demonstrates their confidence in and support of CDA and the Dental Awareness Program.

Moreover, the provincial corporate bodies are looking increasingly to CDA to provide leadership and continuity of DAP projects and material resources. CDA's commitment to this program has also created expectations from governments, the corporate business sector and the membership at large. For all these reasons the following motion was passed:

RESOLVED:

86.29 WHEREAS Manifest Communications Inc. has shown very positive results in the Dental Awareness Program to date, and

WHEREAS there has been very positive feedback from the provincial Corporate Bodies and other "grass roots" segments of the Association, and

WHEREAS the Dental Awareness Program is just now starting to gain both momentum and leverage in the National corporate business community,

THAT the Council on Information Services strongly recommends that CDA maintain an ongoing commitment to the Dental Awareness Program;

THAT the Council on Information Services strongly recommends that Manifest Communications Inc. be retained as consultants for the Dental Awareness Program, years 3 and 4; and

THAT Manifest Communications Inc. present different program proposals and budgets for the continuation of the Dental Awareness Program, to be submitted at the next Council meeting.

ADOPTED

Items not Requiring Board Action

3. Dental Health Month 1986

Preparations are under way for this year's campaign. The unifying theme for Dental Health Month is the same as that of the Dental Awareness Program: "Dental Health: Good for Life". Corporate bodies have adopted this theme for their 1986 Dental Health Month activities. All DHM materials are designed to be used year round, as part of the Dental Awareness Program. Key elements in this year's campaign include:

- The publication of the second National Dental Health Checkup in Chatelaine magazine (on the news-stands April 10), with a circulation of 1.4 million English and 300,000 French, and an additional half million overruns, will reach an estimated 6 million Canadians. Overruns of the Checkup will be distributed to the provincial associations, all CDA members and through pharmacies.
- DHM materials - poster, decal, button, all bearing the "Dental Health: Good for Life" logo;
- A direct mailing to CDA members of DHM materials (via the March CDA Communique) including: the first fact sheet series for patient education and the second DAP Report, on "Communicating Care" to patients;
- Provincial kits mailed to each corporate body include public service ads, planning and media kits, activity planner and numerous other resources;
- Planning kits distributed to local chapters, dental societies and public health units. This kit has been modified to suit the needs of community organizers;

-
- Media Relations activity will intensify during the period leading up to and during DHM. Specific information about the "Good for Life" program and DHM will be sent to national and local media outlets. In addition, DHM media kits will be distributed to major media outlets and key government contacts;
 - Direct distribution of DHM materials to 2,500 pharmacies through corporate sponsorship;
 - IDA and Guardian drug stores have arranged to promote DHM/DAP by printing the "Good for Life" logo in their respective promotional flyers during April.

4. Media Relations

The media relations program, an important component of DAP, is operating on a number of levels. Media contacts are being strengthened and expanded. CDA spokespersons are being contacted whenever suitable media opportunities arise.

Since the launch of DAP, media coverage of dentistry and dental health issues has increased by approximately 250%. Between April 1985 and January 1986, 766 print articles were identified. As well, 32 radio and 10 television broadcasts were monitored. (Electronic monitoring has been done on a sporadic basis, but will be increased in the coming months.) Analysis of these media items shows that the nature of media coverage has improved, revealing a growing interest in dental health issues.

A media relations strategy for the Dental Awareness Program began in January and will intensify during the period leading up to DHM. The strategy, designed to maximize exposure to the "Good for Life" program, operates on two levels simultaneously:

- Key DAP messages will be incorporated in a number of theme topics, with good potential for both broadcast and print media. Theme topics include: the changing face of dentistry and the caring dental health professional, periodontal disease and preventive dental care. In addition, four major print and electronic media coverages are planned for the next six to nine months.
- A number of media packages, each containing specific information, will be sent to mainstream and secondary media outlets on specific dates, between January and late March. Key events include the launch of CDA's public service advertisement campaign and DHM. Each event will be the focal point for media activities, such as broadcast interviews and articles in magazines and newspapers.

5. Public Service Print Advertising Campaign

In April 1986 CDA will launch a "Good for Life" public service ad campaign. Initially the campaign will be in print only. Phase one involves soliciting public service space from daily and weekly newspapers. Phase two targets national magazines.

6. Provincial Relations

Corporate bodies are kept informed about DAP/DHM activities on a regular basis. Between February and April, Chief Executive Officers and DHM chairmen will receive bi-weekly provincial updates on DHM materials and projects. In 1985, we provided DAP consulting/planning workshops for nine out of ten corporate bodies. The tenth workshop is scheduled for June. We have also created and discussed joint-venture projects with selected corporate bodies.

Council recommended that Manifest Communications explore the possibility of implementing a series of lectures, seminars and media workshops on the DAP, to be offered to dental societies and provincial bodies on a cost-recovery basis. It was also noted that CDA members not actively involved in DAP should have the opportunity to attend a seminar. Council therefore recommended that Manifest be invited by the CDA Convention Organizing Committee to present a half-day seminar on dental marketing at CDA's annual convention in Halifax in August 1986.

7. Member Relations

Communication to CDA members has been expanded and regularized through: the DAP Report (quarterly), Communique reports (quarterly) and Journal update pages (monthly). Members have access to a growing variety of DAP patient-education resources: DHM kits, the Checkup 1986, "What Every Adult Should Know" and the Fact Sheet program. As more resources are developed, they too will become available to members.

8. Targeted Programming

-As outlined earlier, the success of DAP to date has been largely dependent upon financial leverage from the corporate business sector. In the last five months, the following major initiatives have been fully funded by corporate sponsors - at no cost to CDA:

-
- Colgate-Palmolive, the sole sponsor of the second National Dental Health Checkup supplement, has committed \$300,000 to this project. Colgate will also cooperate with CDA in distributing overruns of the supplement to pharmacies, and public health and dental clinics.
 - "What Every Adult Should Know About Dental Health" is a CDA publication project exclusively sponsored by Oral B, for a period of three years at a direct cost of \$120,000 in year one. Oral B is also committing an additional \$130,000 for direct mail, packaging and distribution to pharmacies and dental offices. The company has committed a total of \$250,000 to this project in 1986.
 - Warner Lambert has arranged to purchase CDA "Good for Life" posters and buttons, and will distribute these items to 2,500 drug stores during DHM.

A number of other projects are under discussion with sponsors including: a radio information series, an adult poster information series and a fall magazine supplement.

- Representatives of McDonald's Restaurants have expressed interest in sponsoring an educational/motivational program for children, designed to generate a high profile for children's dental health. Program opportunities are currently being discussed, potentially leading to a long-term program with CDA.
- A Recall Program involving instructional and resource materials is being developed to assist the dental team in their efforts to bring patients into their office for regular checkups. This program addresses the "busyness factor" and the need for specific methods to communicate care to patients in the dental office. It is anticipated that sponsors for this program will be identified by the spring of 1986, and that the kits should be ready for distribution by the fall.

9. Leverage

To date, CDA has obtained \$900,000 in leverage. With projects under development, DAP should reach its two-year leverage goal of four-to-one.

10. Research

Two major research initiatives were conducted in 1985. The results of these surveys helped to identify target audiences and develop appropriate DAP strategies and resource materials. The survey of health educators indicated there is a real need for educational materials geared to adults. It also helped determine the type of resources health educators want and need. The Gallup National Omnibus Poll measured the public's knowledge and perception of dental health. The results revealed a need for better public and patient education, especially geared toward adults. Dental Awareness programming efforts are designed to meet these needs.

Each corporate body received a copy of the Gallup poll, requesting it be used on a confidential basis. In addition, an analysis of the poll and its implications for individual dental practices was published in the first Dental Awareness Program Report, mailed to all members via the CDA Communique in December.

11. Information to Members About AIDS

In response to organized dentistry's concern about AIDS, CDA held a news conference on September 30, 1985, in Ottawa, to address this issue. This event generated substantial print and broadcast media coverage, including a front-page article in the Globe and Mail. In addition, three articles on AIDS and the implications for the dental profession were published in the December Communique, which was mailed to all dentists in Canada. An edited master tape on the AIDS news conference has been produced. This tape can be duplicated in a Beta, VHS or 3/4 inch format. The cost of duplication will vary between \$17.50 and \$31.50, depending on the format. Copies of the tape can be ordered directly through CDA.

12. Council's Roles and Responsibilities

At both the November and January meetings, Council reviewed its role vis-à-vis the Dental Awareness Program. Council agreed that it should continue to remain responsible for strategic decisions and policy issues relating to the program, and that Manifest should be responsible for the actual development and production of DAP projects. Council recommended that its roles, responsibilities and new orientation be passed on to the Chairman of CDA's Committee on Roles and Responsibilities for review.

Respectfully submitted,

Y. Kamachi, D.D.S.
Chairman,
Council on Information Services

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Information Services with appreciation.

1985 Financial Statement

DHM & DAP

	<u>1985 Budget</u>	<u>Actuals</u>	<u>1986 Budget</u>
<u>Revenue</u>			
DHM	\$ 20,000	\$ 22,700	\$ 20,000
Pamphlets	70,000	78,728	75,000
<u>Expenses</u>			
DHM	75,000	351,807*	75,000
DAP	200,000		142,000
DAP Admin.	30,000	27,745	30,000
Pamphlets	70,000	61,489	74,200

COUNCIL ON INSURANCE AND INVESTMENT

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members of the CDSPI Board of Directors are:

Dr. G. Anthony	Atlantic Provinces
Dr. G.F. Copithorne	British Columbia
Dr. R. Dupont	CDA Representative for Quebec
Dr. C.R. Hill	Manitoba and Saskatchewan
Dr. D. Montminy	Quebec
Dr. R.L. Moran	CDA Representative for Ontario
Dr. R.L. Rasmussen	Alberta
Dr. R.R. Schiewe	Ontario
Brig. Gen. J.N. Wright	CDA Executive Liaison

Members of the CDSPI Management Committee are:

Dr. J.E. Durran	Burlington	President
Dr. R.L. Moran	Toronto	Treasurer
Dr. M.D. Chardendoff	Toronto	Secretary

This report includes all information that requires reporting and which has become available since October, 1985. The CDSPI Board met on October 5 and 6, 1985, and December 6 and 7, 1985.

ITEMS REQUIRING BOARD ACTION

1. CDA RSP Eligibility

At the December Meeting of CDSPI, the subject of eligibility for CDA RSP was reconsidered at the direction of the CDA Board. The CDSPI Board adopted the following for consideration by the CDA.

RESOLVED:

- 86.30** **THAT a member in good standing of the CDA, and/or a corporate body of the CDA, and that member's spouse, be eligible to participate in the Canadian Dental Association Retirement Savings Plan.**

ADOPTED

COUNCIL ON INSURANCE AND INVESTMENT

RESOLVED:

- 86.31 **THAT** any staff member of the following named organizations may participate in the plan:

Canadian Dental Association
Alberta Dental Association
College of Dental Surgeons of British Columbia
Manitoba Dental Association
New Brunswick Dental Society
Newfoundland Dental Association
Newfoundland Dental Board
Nova Scotia Dental Association
Provincial Dental Board of Nova Scotia
Ontario Dental Association
Royal College of Dental Surgeons of Ontario
Dental Association of Prince Edward Island
Association des chirurgiens dentistes du Québec
Ordre des dentistes du Québec
College of Dental Surgeons of Saskatchewan
National Dental Examining Board of Canada
Royal College of Dentists of Canada
Canadian Dental Service Plans Inc.
Canadian Fund for Dental Education.
Association of Canadian Faculties of Dentistry

ADOPTED

RESOLVED:

- 86.32 **THAT** any individual who does not maintain eligibility will not be removed from the plan, but cannot continue to contribute until eligibility requirements are met.

ADOPTED

RESOLVED:

- 86.33 **THAT** the CDA permit an eligible dentist's auxiliary staff to participate in the CDA/RSP, subject to the same eligibility requirements as participation in CDIP.

ADOPTED

COUNCIL ON INSURANCE AND INVESTMENT

2. Pooling Limits - Basic Life Program

In order for the Executive and Board of the CDA to be able to consider the accompanying motion, it is necessary that the members understand what is meant by Pooling Limits.

At the present time, the Basic Life program of CDIP shares the risk of claims made as a result of the death of a participant up to \$210,000 of coverage. In other words, if a participant has coverage of \$300,000 and death occurs, then the CDIP program is responsible for payment to the beneficiary of the first \$210,000 and the insurance company pays the remaining \$90,000. Naturally, there is a premium cost which is charged by the insurer for the protection which is purchased that provides the coverage beyond the \$210,000 limit which is presently covered by the CDIP program.

The Board of CDSPI commissioned a study for the purpose of determining the appropriate pooling limit which should exist at this point in time. This study is attached as **Appendix A**. As a result of the conclusions of the study and its own judgements, the Board of CDSPI is recommending to the CDA the following:

RESOLVED:

86.34 **THAT for the policy year 1986, the pooling limit for the Basic Life Program be \$300,000.**

ADOPTED

Since it is deemed to be prudent to initiate this for the year 1986, we respectfully request that the CDA Executive approve the change at their February Meeting and seek ratification at the CDA Board in April.

3. Insurance Plan for Dentists' Staff

In early 1985, the Management Committee discussed the possibility of developing some group insurance packages for the staff of eligible dentists.

Our first step was to obtain a legal opinion as to whether or not there would be any problems regarding our offering this form of insurance to non-CDA members. A legal opinion was obtained which outlined the procedure which would permit us to proceed. A copy of this opinion is attached (**Appendix B-1**).

COUNCIL ON INSURANCE AND INVESTMENT

TPF&C was then asked to design the program, which was reviewed by the Management Committee in early August. The design of the program was considered to be proper in relating to the principles and philosophy that should be attached to this type of plan, and the Management Committee recommended that TPF&C proceed in attempting to find an insurer.

Seven insurance companies were selected, specifications prepared, and a request for quotations was made.

In late September, the Management Committee received a report from TPF&C relating to their findings, based on their solicitation for quotations.

As a result of this report, the Management Committee came to the conclusion that the program, as designed, was not appropriate, as only two of the seven insurers even agreed to quote. Also, of the seven that were asked to quote, none would provide dental coverage.

The Management Committee then spent considerable time reviewing the entire philosophy, and finally recommended that TPF&C look at providing a staff package, within the current CDIP framework. The reason for this was that, administratively, there would be virtually no additional costs, and in practicality, we would be offering for the auxiliaries portions of a program that had already been tested and proven to work for their employers.

In the discussions, certain conclusions were reached, one of which was that any type of dental or extended health care benefit was not going to be possible, and should therefore be eliminated from the Plan. The basic plan to be evaluated would contain Basic Life, Accidental Death and Dismemberment, and Long Term Disability coverage. The Long Term Disability coverage should be linked with Unemployment Insurance benefits that can be obtained for the first 17 weeks of disability.

As a result of these further discussions, TPF&C have provided a report of November 1985, which is attached (**Appendix B-2**). This report has been reviewed by the CDSPI Board and, in our opinion, is an appropriate package that can be marketed appropriately to dentists for their staff.

Therefore, the CDSPI Board recommends to the CDA:

RESOLVED:

86.35 **THAT a group insurance package for dentists' staff, as outlined in the report of TPF&C dated November 1985, be implemented effective July 1, 1986.**

ADOPTED

COUNCIL ON INSURANCE AND INVESTMENT

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

4. CDIP Plan Experience

Since the reporting requirements of the CDA demand an early submission, the Plan Experience Statements for 1985 are not yet available. They will be presented as a hand-out at the Board Meeting.

5. CDIP Plan Comparisons

As part of our continuing assessment of the advantages which accrue to a dentist who participates in the CDIP program, Towers, Perrin, Forster and Crosby were asked to comment on the competitiveness of our Life Premium Rates relative to the individual market for similar insurance policies.

Their report (**Appendix C attached**) shows that a dentist who participates in the Basic Life program will pay only 60% of the premium that he would have had to pay if he bought the coverage from any of the companies that were surveyed. We are pleased to report this to the CDA Board.

6. CDA RSP

The past year has seen the RSP achieve its best results ever. Solid improvement has been made in all areas, such as new accounts, amount of contributions, total amount of money transferred in, the actual number of transfers-in, a substantial reduction in the number of deregistrations and the outflow of money through deregistrations, a net gain in the number of accounts and dollar amount, as well as total number of participants. (**See Appendix D attached**)

These results were possible due to the revitalization of the CDA RSP, with enhancements such as weekly valuations of Funds, and the new Guaranteed Fund that has assets in excess of \$1,000,000. New promotional material such as the brochure, RSP Portfolio, slide chart, and the distinctive striped covers of these items, support the service.

Added to this is the promotional support by way of mail stuffers, articles that appeared in various periodicals, and the advertisements which started to appear in the CDA Journal in the last quarter of 1985.

COUNCIL ON INSURANCE AND INVESTMENT

The main highlights for 1985 are the total contributions, amounting to \$2,522,000, representing a 131% increase over the previous year. Transfers-in showed an increase of 169% in actual number of transfers (218 compared to 129 a year ago), with dollar volume being \$1,571,000 compared to \$695,000 a year ago - an increase of 126%.

Another area that indicates that we are developing a competitive and attractive service is the reduction in the actual number of deregistrations. For the comparable reporting period, we have had 70 deregistrations, compared to 110 a year ago, representing \$2,361,000 and \$3,379,000 respectively. This is a reduction of over \$1,000,000, or 30%.

We should mention that the reporting year for RSP's is from March 2nd to March 1st, so that the comparisons we refer to are for a 10-month period for the current vs previous year.

Analyzing the deregistrations, we identify annuity purchases at a level equal to the previous year, which is approximately \$1,000,000 for each year. What this means is that we have been able to slow down the pure deregistrations, or transfers to other RSP's, by as much as 56% in actual dollars.

There are two other encouraging areas. The first is the net gain in dollars. For the first time in five years, we are in a net position, \$161,166.47 vs a decrease of \$2,289,396.15 a year ago. In actual dollars this is an improvement of \$2,450,562.62.

The second area is the total number of participants or accounts that now stands at 1,452, or 235 more than a year ago.

In actual dollars under administration, the total plan has grown from \$40,637,355 to more than \$50,000,000 as at the end of December 1985. This is an increase of 25%.

We look for a continuing growth pattern in the coming year, with a promotional program in place for the full year, and with a strong emphasis on service to participants.

The following provides an added view of fund growth in chart form:

COUNCIL ON INSURANCE AND INVESTMENT

<u>Funds</u>	\$ Balances			
	Feb. 28 1983	May 31 1984	May 31 1985	Dec. 31 1985
Fixed Income	9,418,370	9,961,714	12,205,980	14,047,130
Equity	15,103,666	16,544,018	19,382,395	21,331,963
Money Market	9,671,430	10,414,321	11,080,125	11,395,502
Balanced	1,116,106	1,785,823	2,260,698	2,679,961
Guaranteed	N/A	N/A	810,129	1,130,000
TOTAL ASSETS	\$35,309,572	\$38,705,876	\$45,739,327	\$50,584,556
<u>No. of accounts</u>	1168	1319	1405	1452

7. Retirement Counselling

As reported at the CDA Annual Meeting in October, our Retirement Services Department, which was then in the process of developing its programs, is now ready to provide the services for which it was developed. The annuity services program is up and running and the Retirement Counselling Seminars are scheduled across the country.

The Pilot seminar was presented by Peter Dennett in Toronto to a group of dentists who agreed to act as critics and dress rehearsal participants. The comments on the critique forms augur well for the future of this service, and CDSPI solicits your support when the seminar is given in your province. The Provinces have already been asked to assist in the promotion.

8. Computer Services

CDSPI is continually seeking new ways in which to provide services to the profession which makes each dentist's day just a little bit easier.

COUNCIL ON INSURANCE AND INVESTMENT

After a great deal of discussion and analysis, it was decided that the area of dental office computerization was one where CDSPI could bring its expertise to bear and do the research and study that might otherwise consume a tremendous amount of time and effort on the part of individual dentists who were trying to decide what computer system should be purchased - or, in fact, if any computer system should be purchased.

Therefore, CDSPI has conducted an in-depth study of more than thirty different Dental Office Management systems that are available for purchase in today's market. As a result of that study, and our perception of the needs of dentists, we have established a Computer Services Department and we will be applying the same principles to the Dental Office Management system that we have applied to the insurance market for dentists in Canada. Our market will first be in Ontario and will then expand on a regular schedule to other areas of Canada.

We anticipate that this new service will meet with the same degree of acceptance as our efforts in other areas. Certainly, our surveys show that the need for this service does exist and we are going to do our best to meet the need.

9. General Insurance Coverages

The problems associated with the availability and purchase of liability insurance have been well publicized in the media. We are, as a group, fortunate to be able to purchase this coverage at a reasonable rate and with a relatively stable degree of predictability regarding availability and coverage. Negotiations for the 1987 year have started, and it is only prudent to warn that there may be some difficulties with respect to the 5 year extensions for malpractice coverage.

10. Restructuring of CDSPI Board

At the Annual Meeting of CDSPI a proposed By-Law change relating to the restructuring of the CDSPI Board was presented to, and voted down by, the Corporate Members. Considerable discussion took place, but no consensus was reached.

It was agreed that the various Corporate Members would return to their Provinces and submit their positions to CDSPI, who would act as a "clearinghouse".

COUNCIL ON INSURANCE AND INVESTMENT

In December of 1985 the Board of CDSPI received, for their information, positions stated by some Provinces. Acting as the "clearinghouse", these have been sent to all Corporate Members, but we have heard nothing further.

Respectfully submitted,

Dr. J.E. Durran, Chairman
Council on Insurance and Investment

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Insurance and Investment with appreciation.

CANADIAN DENTISTS' INSURANCE PROGRAM

POOLING LIMIT FOR BASIC LIFE PROGRAM

Kenneth T. Ransby

November, 1985

CANADIAN DENTISTS' INSURANCE PROGRAM

POOLING LIMIT FOR BASIC LIFE PROGRAM

I. INTRODUCTION

At the present time, CDIP basic life insurance in excess of \$210,000 on any individual participant is pooled. Under this experience rating technique, premiums and claims paid in respect of any "excess" volumes of insurance are removed from the financial accounts of CDIP and merged with Imperial Life's overall book of group life insurance. The status of the CDIP experience rating account, and future premium rate levels, are then determined by reference only to the experience on the non-pooled or "retention" amounts of insurance up to the \$210,000 pooling level.

In a letter to Kingsley Butler dated August 29, 1985, we stated that the current pooling level was too low, and should be increased to \$300,000. We were then asked by CDSPI to provide a more detailed report as to the effect that this change in the pooling would have on the overall experience and finances of the program.

By using TPF&C's computer-based Risk Model, we have been able to quantify the effect of introducing this proposed change in the underwriting arrangements. We are pleased to provide this report on the results of our analyses.

II. METHODOLOGY

CDSPI provided data as at January 1, 1985 on participants covered for basic life insurance under CDIP. Using this data, we applied our computer based Risk Model to generate the anticipated aggregate distributions of death and disability waiver claims for the basic life insurance.

The mortality basis used in our analysis was developed by using a standard table developed by TPF&C, with adjustments to reflect anticipated experience under the CDIP. For purposes of making these adjustments, we assumed that there is a mortality margin of approximately 10% underlying the premium rates now being paid under CDIP.

It should be noted, however, that the purpose of the risk analysis is not to examine the sufficiency of the premium rates now being paid. Rather, our Risk Model is utilized to measure the probability in any single year that aggregate claim charges will range in dollar amounts above or below a reasonable "expected" level. If the overall experience of CDIP is better or worse than anticipated by our expected level, surpluses in the plan will be increased (or decreased), notwithstanding the effect of variations in claims from year to year.

In order to illustrate the effect of increasing the large amount pooling level, we examined aggregate claims distributions by assuming pooling levels of \$210,000, \$250,000 and \$300,000, and by assuming that the plan is fully experience rated with no pooling.

III. RESULTS OF THE ANALYSIS

When the Risk Model was run, it was determined that the expected level of aggregate claims in any policy year was \$1,930,000. Again, we emphasize that the important statistic in this analysis is not this expected claim level -- which is dependent upon our assumed overall level of mortality -- but the range of aggregate claims around the expected level.

We analyzed the aggregate claims distributions at the various assumed pooling levels, and determined the following:

Table 1

Threshold Level	Underwriting Surplus (Deficit)	Probability of Claims + Pooling Charges Exceeding Threshold			
		Pooling at \$210,000	Pooling at \$250,000	Pooling at \$300,000	No Pooling
\$ 930,000	\$1,000,000	99%	98%	97%	95%
1,430,000	500,000	85	82	80	76
1,930,000	0	47	47	47	47
2,430,000	(500,000)	15	17	19	22
2,930,000	(1,000,000)	3	4	5	8
3,430,000	(1,500,000)	less than 1	less than 1	1	2
Pooling Charges		\$340,000	\$235,000	\$137,000	\$0

From an examination of Table 1, the following should be noted:

1. For each assumed pooling level, we have determined the probabilities that total claims charges (experience-rated claims plus pooling charges) will exceed selected "threshold levels".

The "threshold level" is compared to the net basic life premium (being \$1,930,000, the expected claims level), to determine the underwriting surplus or deficit at that threshold level. Variable expenses associated with paying fewer or more claims than expected, are ignored in this analysis because they are relatively insignificant.

2. As the pooling level is increased from \$210,000 to \$250,000 and \$300,000, and then removed entirely, the probability of experiencing a large deficit (say, \$1,000,000 or greater in any one year) is not increased significantly. For example, the probability of experiencing a deficit in excess of \$1,000,000 in any one year increases only from 3% to 5% if the pooling level is raised from \$210,000 to \$300,000.
3. The pooling charges calculated by the Risk Model, when loaded for expenses and the assumed mortality margin noted in the previous section, are in line with the gross pooling charges noted in our letter of August 29, 1985.

<u>Pooling Level</u>	<u>Risk Model Pooling Charges</u>		<u>Aug. 29/85 Risk Charges</u>
	<u>Net</u>	<u>Gross</u>	<u>Gross</u>
\$210,000	\$340,000	\$474,000	\$480,000
250,000	235,000	328,000	332,500
300,000	137,000	191,000	192,500

The minor differences in the gross pooling charges are due to slight differences in the mortality basis used in the risk model versus the CDIP premium rate schedule, and are not material.

The results noted in Table 1 may be re-expressed to depict the probability that aggregate claims charges will fall within specified threshold ranges, thereby creating ranges of surplus or deficit in any year:

Table 2

Underwriting Surplus (Deficit)	Probability of Occurrence			
	Pooling at \$210,000	Pooling at \$250,000	Pooling at \$300,000	No Pooling
Greater than \$1,000,000	1%	2%	3%	5%
\$500,000 to \$1,000,000	14	16	17	19
0 to 500,000	38	35	33	29
0 to (500,000)	32	30	28	25
(500,000) to (1,000,000)	12	13	14	14
(1,000,000) to (1,500,000)	2	3	4	6
Greater than (1,500,000)	less than 1	less than 1	1	2

The probabilities shown in Table 2 are graphically depicted in Appendix A.

The trade-off associated with increasing the pooling limit is clear from an analysis of Table 2. As the pooling limit is increased, the probability of experiencing a small surplus or deficit decreases, but the probability of experiencing a large surplus or deficit increases. The change in the probabilities of large deficits is not so significant, however, as to jeopardize the expected financial health of CDIP.

It should be recalled also that the basic life account had a Rate Stabilization Reserve of approximately \$675,000 as at the end of 1984, and a further \$1,000,000 of the surplus account has been earmarked as a contingency fund. These two reserves provide additional buffer against the necessity for rate increases if a large experience deficit were to arise in a given year.

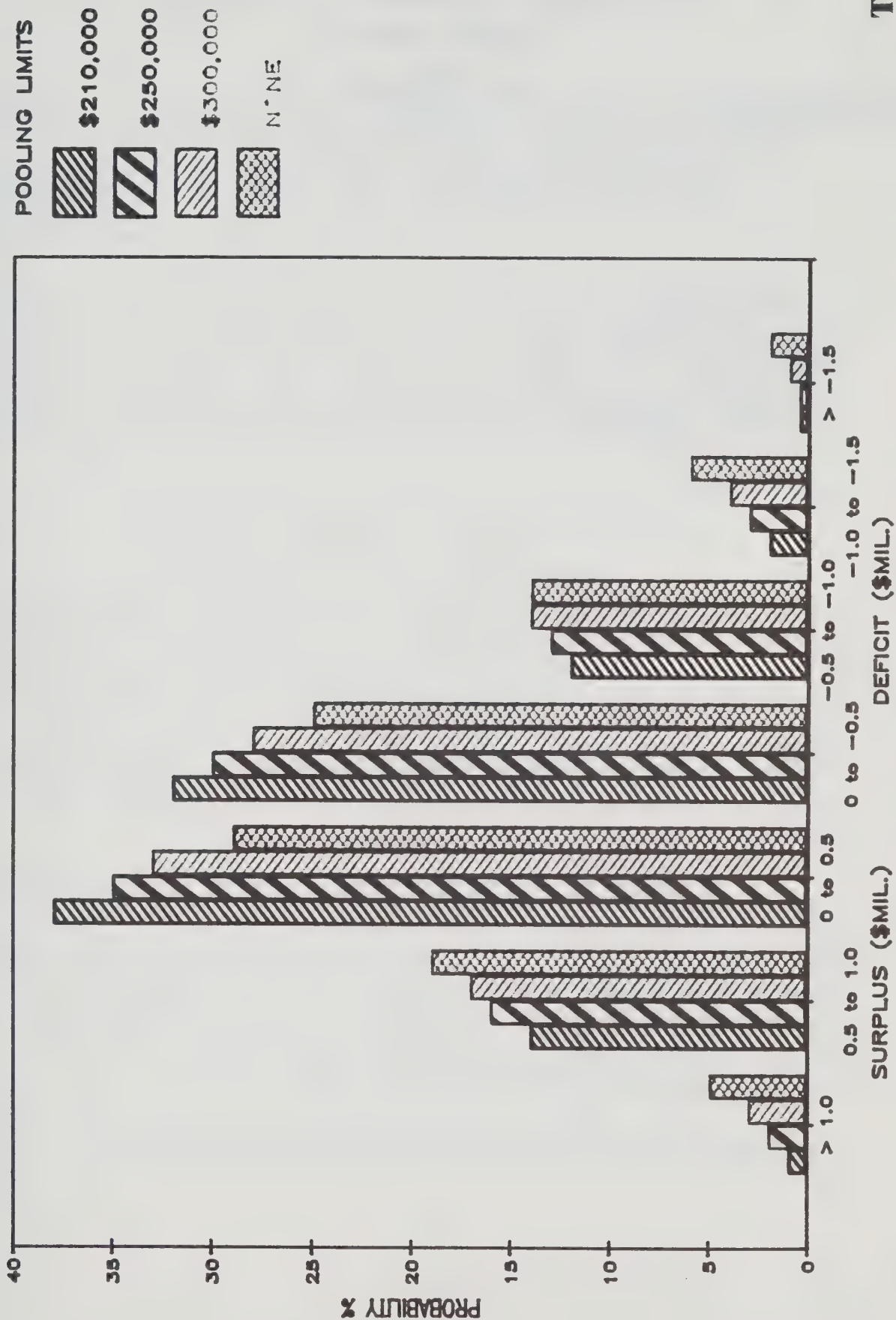
In conclusion, we recommend that the current \$210,000 large amount pooling level be increased to \$300,000, commencing in the 1986 policy year.

IV. SUMMARY

We utilized TPF&C's Risk Model to quantify the effect of increasing the large amount pooling level under the CDIP basic life program.

Increasing the pooling level from \$210,000 to \$300,000 did not significantly increase the probability that a large deficit will be experienced in any given year. We therefore recommend that the pooling limit be increased to \$300,000, commencing with the 1986 policy year.

CANADIAN DENTISTS' INSURANCE PROGRAM BASIC LIFE INSURANCE POOLING LIMITS



CAMPBELL, GODFREY & LEWTAS

BARRISTERS & SOLICITORS

TELEX 065-24553
TELECOPIER (416) 362-2381
CABLE ADDRESS "ARNOLDI" TORONTO

P.O. BOX 36
TORONTO-DOMINION CENTRE
TORONTO, CANADA
M5K 1C5

GENERAL TELEPHONE
(416) 362-2401

A. BETH MOORE
DIRECT LINE (416) 868-3427
OUR REF: 030328-004

February 28, 1985.

Mr. K.D. Butler,
General Manager,
Canadian Dental Service
Plans Inc.,
Suite 600, 2 Lansing Square,
WILLOWDALE, Ontario,
M2J 4Z3

Dear Kingsley:

Group Insurance Packages for Dentists'
Staff

I understand from our telephone discussion yesterday that the group insurance packages for dentists' staff which you have been reviewing would involve a package of life, accidental death and disability and longterm disability coverage which would be offered to dentists who are eligible to participate in CDIP. The dentist could then offer the package to his or her staff, either as an employment benefit or on the basis that the employee paid all or part of the premium, presumably as a deduction from income. The dentist would be invoiced for the premium. The employees would continue to be eligible to participate, if they chose to do so, in the other CDIP insurance plans.

Since the proposed package is to be offered through members of the CDA and the provincial associations to persons who are already eligible to participate in CDIP it does not appear to me to involve an expansion of the CDIP program. The authorizations originally obtained from the Superintendents of Insurance contemplated participation in CDIP by employees of eligible dentists and of the participating associations so there is also no expansion of the group to whom the various plans are being offered beyond what was disclosed in our correspondence with the Superintendents' offices.

The necessity of restricting the persons who could participate in the retirement savings plan program arose

...2

specifically because of the disclosure requirements in the Insurance Act relating to the offering of variable rate annuity contracts which are not "group variable insurance contracts". The considerations on which the decision to exclude employees of dentists from the RSP program was based are therefore different from those which apply to the determination of who can participate in the CDIP program.

It is, of course, very important that the plans involved in the CDIP program not be offered to or promoted among members of the general public. I assume that since the purchase of the staff package is to be made by the dentist for his or her staff that the promotional materials relating to the package will be distributed to the eligible dentists and not directly to members of the hygienists' associations or other such groups who might not be otherwise eligible to participate in CDIP.

Yours truly,

A handwritten signature in cursive script, appearing to read "A.B. Moore".

A.B. Moore

ABM:kh

CANADIAN DENTAL ASSOCIATION

PROPOSED BENEFITS PACKAGE
FOR DENTISTS' STAFF

Kenneth T. Ransby
Janet I. Zwarick

November, 1985

CANADIAN DENTAL ASSOCIATION

PROPOSED BENEFITS PACKAGE
FOR DENTISTS' STAFF

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II BENEFITS PACKAGE DESIGN	2
III METHOD OF UNDERWRITING	3
IV PREMIUM RATES	4

Exhibits

- 1 Summary of Benefit Provisions
- 2 Annual Premiums for Staff Package

I. INTRODUCTION

In September, 1985, TPF&C prepared a report which provided an analysis of the insurer quotations on a proposed group benefits program for the staff of dentists who participate in CDIP.

The report was reviewed by the Management Committee of CDSPI. Following the review, TPF&C was requested to present a report which outlined the costs of providing a basic "package" under the current CDIP underwriting arrangements.

The purpose of this report is to present an outline of the benefits to be covered under the proposed package and the associated premium costs.

II. BENEFITS PACKAGE DESIGN

The design of the proposed program is very simple and includes three elements of insurance; namely, life, long term disability and accidental death and dismemberment. The package covers the following benefits:

Basic Life Insurance	\$25,000
Long Term Disability	
- employees earning less than \$18,000 p.a.	\$750 per month
- employees earning \$18,000 p.a. and over	\$1,000 per month
Accidental Death and Dismemberment	\$25,000

A detailed summary of benefit provisions is included as Exhibit 1 to this report.

III. METHOD OF UNDERWRITING

Although the proposed staff program is intended to be a package available to staff only, it would not be underwritten as a separate policy. It is proposed that each of the three elements of the package be included under the existing CDIP arrangements with Imperial Life and Seaboard Life.

In order to determine the ongoing sufficiency of the premium rates, separate premium and claims figures would be maintained and monitored.

Benefits would be individually underwritten and, as such, would be subject to medical evidence.

IV. PREMIUM RATES

The overall premium rates of the staff program have been structured to make the package attractive to the eligible employees. The annual premium rates for the package are lower than the cost of any combination of a similar level of benefits available under CDIP. The rates are in five year age bands and divided into the following four sections:

1. Non-smoker
2. Smoker
3. \$750 LTD benefit
4. \$1,000 LTD benefit

We emphasize that the non-smoker/smoker rates are applicable to life insurance only. Exhibit 2 details the annual premium costs for the proposed package.

It is intended that the employees make their own arrangements with regard to the cost sharing arrangements with their employers.

Summary of Benefit Provisions

ELIGIBILITY: All full-time employees under age 65 who work at least 30 hours per week and are employed by a dentist who is enrolled in the Canadian Dental Association group insurance program.

BASIC GROUP LIFE INSURANCE

Death Benefit \$25,000
Disability Waiver of Premium to age 65

ACCIDENTAL DEATH & DISMEMBERMENT

Principal Sum \$25,000
Disability Waiver of Premium to age 65
Schedule of Losses If injury shall, within 365 days of the date of the accident causing such injury, result in any of the following losses the insurer will pay for loss of or permanent and total loss of use of:

- Life.....The Principal Sum
- Both Hands or Feet.....The Principal Sum
- Entire Sight of Both Eyes.....The Principal Sum
- One Hand, One Foot or
Entire Sight of One Eye.....75% of The Principal Sum
- Thumb or Index Finger.....50% of The Principal Sum

"Loss" as above used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to thumb and index finger means complete severance at or above the first phalange; as used with reference to eye means the irrecoverable loss of the entire sight thereof.

Any indemnity payable for Loss of Use shall be paid only if such loss is permanent, total and irrecoverable and shall have been continuous for a period of twelve months from the date of the accident.

LONG TERM DISABILITY

Benefit	\$750 per month for employees who earn less than \$18,000 per annum. \$1,000 per month for employees who earn \$18,000 or more per annum.
Maximum Benefit from All Sources	85% of pre-disability gross earnings.
Elimination Period	17 weeks (119 days).
Definition of Disability	2 year own occupation, any occupation thereafter.
Rehabilitation Earnings Offset	50% for first 24 months of benefit.
Pre-existing Conditions	Not covered.

ANNUAL PREMIUMS FOR STAFF PACKAGE

<u>Age</u>	<u>Plan A</u>	<u>Plan B</u>	<u>Plan C</u>	<u>Plan D</u>
under 25	\$76.70	\$91.50	\$80.90	\$95.70
25 - 29	85.95	103.40	91.65	109.10
30 - 34	97.98	118.80	106.08	126.90
35 - 39	116.05	141.50	127.25	152.70
40 - 44	161.73	199.10	179.13	216.50
45 - 49	217.63	266.90	246.83	296.10
50 - 54	296.05	360.70	343.15	407.80
55 - 59	347.40	421.20	404.00	477.80
60 - 64	456.13	536.70	526.03	606.60

Notes:

- Plan A includes non-smoker life insurance, AD&D and a \$750 LTD benefit
- Plan B includes non-smoker life insurance, AD&D and a \$1,000 LTD benefit
- Plan C includes smoker life insurance, AD&D and a \$750 LTD benefit
- Plan D includes smoker life insurance, AD&D and a \$1,000 LTD benefit

APPENDIX C

TOWERS, PERRIN, FORSTER & CROSBY

250 BLOOR STREET EAST, SUITE 1100

TORONTO, ONTARIO M4W 3N3

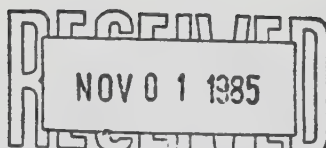
(416) 960-2700

DIRECT DIAL

960-2706

November 1, 1985

Ref. No. 00669/018



Mr. Kingsley D. Butler
General Manager
Canadian Dental Service Plans Inc.
Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

Re: Analysis of Life Premium Rates

As requested, we have examined the competitiveness of the term life premium rates under CDIP, relative to those available in the individual market for similar insurance policies. In addition, we have examined the smoker premium rate "subsidies" which exist under CDIP. We are pleased to provide herein a summary of our analysis.

1. COMPETITIVENESS OF RATES

In Tables 1, 2, 3 and 4 attached to this letter, a comparison is made of the premium rates per \$10,000 of insurance charged under CDIP, and as charged by a number of underwriters that market similar 5-year renewable term policies (with waiver of premium) in Canada.

For purposes of these illustrations, policy fees have been factored into the unit rates by assuming that an individual policy for \$150,000 (approximately the average policy under CDIP) is purchased.

Table 1 - Male Non-Smokers

For the age bands illustrated, premium rates under CDIP vary from 52% to 64% of the average market rates. The CDIP rates are lower than any other market rates at all ages. When CDIP and average market rates were weighted by the volumes of insurance, it was determined that, overall, CDIP rates were 60% of average market rates.

...../2

To: Mr. Kingsley D. Butler
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Date: November 1, 1985

Table 2 - Male Smokers

For the age bands illustrated, premium rates under CDIP vary from 44% to 53% of the average market rates at all ages. When CDIP and average market rates were weighted by volumes of insurance, it was determined that, overall, CDIP rates were 50% of the average market rates.

Table 3 - Female Non-Smokers

In Table 3 (and in Table 4) female rates are shown only for five of the competing insurers, since the female rates for the remaining four insurers were not published. We note, however, that the male premium rate comparisons are more critical due to the heavy male content of the CDIP group.

For the age bands illustrated, premium rates under CDIP vary from 58% to 90% of the average market rates for females. The CDIP rates were lower than any other market rates at all ages (with one exception in the 50-54 age band). When CDIP and average market rates were weighted by volumes of insurance, it was determined that, overall, CDIP rates were 73% of average market rates.

Table 4 - Female Smokers

For the age bands illustrated, premium rates under CDIP vary from 57% to 73% of the average market rates. The CDIP rates were lower than any other market rates at all ages. When CDIP and average market rates were weighted by volumes of insurance, it was determined that, overall, CDIP rates were 62% of average market rates.

2. PREMIUM RATE "SUBSIDY" FOR CDIP SMOKERS

The non-smoker premium rates were lowered under CDIP in 1985 in order to give non-smokers a discount on their term life premiums which was more in line with overall insurance industry practice.

The revised non-smoker rate schedule which we recommended was designed to be in line with the expected mortality of the non-smoker group. In other words, the revised non-smoker rates were designed to be self-supporting.

In our first Benefit Plan Evaluation report, we noted that "if CDSPI wishes to provide a bigger differential between the rates for non-smokers and those for smokers, the following options are available:

(i) Decrease rates for non-smokers and increase rates for smokers...

OR

(ii) Maintain rates for smokers at their present level, reduce rates for non-smokers, and subsidize the resulting rate structure."

To: Mr. Kingsley D. Butler

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Date: November 1, 1985

The CDA and CDSPI adopted the second course of action in 1985. It was determined that the overall premium rate subsidy was approximately \$430,000 per year. Since the non-smoker rates were designed to be self-supporting, the subsidy was then (and is now) with respect to the smoker group. We concurred with the subsidization approach, because the subsidy could be met by interest earnings of the existing life surplus and rates did not have to be increased for the one-third of the group which did not qualify for the discounted non-smoker rates.

As discussed above, the overall market ratios are 60% for non-smokers and 50% for smokers. Consequently, if the smoker rates were to be increased by approximately 20%, the market ratio for male smokers would be increased to 60% and would be in line with the non-smoker group. We note, however, that a 20% increase in the smoker rates would represent an annual premium increase of only \$160,000, or slightly more than one-third of the present subsidy.

Given the significant competitive advantage of the CDIP rates, the smoker rates could be increased sufficiently to eliminate the subsidy entirely. In doing so, however, the smoker rates would have to be increased by approximately 50%. This would present at least three significant problems:

- the smoker and non-smoker market ratios would again be different, this time with the non-smokers having the relative advantage.
- the CDIP rates for females would be uncompetitive at a number of ages.
- significant adverse reaction is to be expected from one-third of the CDIP group which qualifies only for the smoker rate schedule.

For these reasons, we conclude that the smoker rates could not be increased sufficiently to eliminate the premium subsidy which exists. The smoker rates could be increased by a lesser amount -- say 20% -- but such action would still invoke adverse member reaction and would not eliminate the premium subsidy.

The CDA and CDSPI may wish to strike a better competitive balance between the term life insurance costs for smokers and non-smokers, without necessitating premium rate increases. If that is the case, the surplus distribution formula could be designed to provide a greater proportionate reduction for non-smokers.

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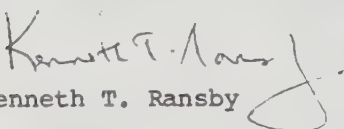
TOWERS, PERRIN, FORSTER & CROSBY

To: Mr. Kingsley D. Butler
Page: -4-
Date: November 1, 1985

We trust that the foregoing is sufficient for purposes of your review. Please let us know if you have any further questions.

Yours very truly,

TPF&C LIMITED


Kenneth T. Ransby

Attachments
/cc

TABLE 1

COMPARISON OF TERM LIFE RATES

	MALE NON-SMOKERS						
	Ages						
	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	\$	\$	\$	\$	\$	\$	\$
CDIP	8.16	9.84	13.80	21.88	34.80	44.36	79.72
MANULIFE	17.43	19.13	25.53	37.13	61.03	94.13	136.53
PAUL REVERE	12.20	14.10	19.60	29.10	46.70	70.20	123.80
NALACO	13.40	15.20	20.50	30.90	63.00	105.70	170.40
IMPERIAL	13.50	15.80	21.30	30.90	46.20	69.90	109.10
SUN	17.47	17.47	22.77	36.67	51.57	80.77	136.67
EQUITABLE	15.77	17.17	24.37	41.87	64.57	96.67	148.57
DOMINION	12.67	15.17	20.17	29.17	42.67	66.67	112.67
COMM. UNION	12.63	14.83	21.73	32.03	52.83	81.13	128.93
ACADIA	<u>16.83</u>	<u>19.03</u>	<u>24.93</u>	<u>41.73</u>	<u>71.93</u>	<u>99.53</u>	<u>114.13</u>
AVERAGE MARKET	14.66	16.43	22.32	34.39	55.61	84.97	131.20
MARKET RATIO	56%	60%	62%	64%	63%	52%	61%

OVERALL MARKET RATIO WEIGHTED BY VOLUMES OF INSURANCE:

CDIP RATE	\$17.61
AVERAGE MARKET RATE	29.50
MARKET RATIO	60%

November 1, 1985

TABLE 2

COMPARISON OF TERM LIFE RATES

MALE SMOKERS

	Ages						
	30-34 \$	35-39 \$	40-44 \$	45-49 \$	50-54 \$	55-59 \$	60-64 \$
CDIP	11.40	14.32	20.76	33.56	53.64	67.00	107.68
MANULIFE	26.33	27.73	42.43	61.53	102.93	140.23	208.13
PAUL REVERE	23.30	28.70	38.60	58.50	81.20	127.50	235.90
NALACO	21.50	27.70	42.50	67.90	136.70	211.60	304.40
IMPERIAL	22.10	26.00	37.50	56.90	86.20	127.60	191.90
SUN	26.57	26.57	37.67	62.17	102.07	149.97	258.97
EQUITABLE	25.27	30.27	42.77	73.27	112.57	167.17	239.77
DOMINION	17.67	23.17	33.67	52.67	80.17	123.67	197.67
COMM. UNION	21.23	28.03	45.93	72.03	113.03	158.53	215.03
ACADIA	24.53	30.63	42.33	71.53	93.83	158.93	181.53
AVERAGE MARKET	23.17	27.64	40.38	64.06	100.97	151.69	225.92
MARKET RATIO	49%	52%	51%	52%	53%	44%	48%

OVERALL MARKET RATIO WEIGHTED BY VOLUMES OF INSURANCE:

CDIP RATE	\$27.78
AVERAGE MARKET RATE	55.41
MARKET RATIO	50%

November 1, 1985

TABLE 3

COMPARISON OF TERM LIFE RATES

FEMALE NON-SMOKERS

	Ages						
	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	\$	\$	\$	\$	\$	\$	\$
CDIP	8.16	9.84	13.80	21.88	34.80	44.36	79.72
SUN	14.97	15.37	18.57	26.27	36.67	52.07	82.37
EQUITABLE	14.27	15.57	20.27	33.87	49.97	71.97	114.97
DOMINION	12.27	14.67	18.57	25.17	34.27	49.07	76.07
COMM. UNION	10.93	13.63	19.43	28.13	39.93	57.83	81.03
ACADIA	17.33	17.53	21.53	31.33	50.33	92.53	87.23
AVERAGE MARKET	13.95	15.35	19.67	28.95	42.23	64.69	88.33
MARKET RATIO	58%	64%	76%	76%	82%	69%	90%

OVERALL MARKET RATIO WEIGHTED BY VOLUMES OF INSURANCE:

CDIP RATE	\$17.61
AVERAGE MARKET RATE	24.18
MARKET RATIO	73%

November 1, 1985

TABLE 4

COMPARISON OF TERM LIFE RATES

FEMALE SMOKERS

	Ages						
	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	\$	\$	\$	\$	\$	\$	\$
CDIP	11.40	14.32	20.76	33.56	53.64	67.00	107.68
SUN	21.77	25.97	32.67	46.27	64.27	94.07	155.27
EQUITABLE	22.97	27.17	35.27	58.87	86.67	123.97	185.17
DOMINION	16.77	21.97	29.77	43.67	61.57	88.57	131.37
COMM. UNION	14.83	19.23	33.03	50.33	63.13	90.13	110.43
ACADIA	24.53	30.63	42.33	71.53	93.83	158.93	181.53
AVERAGE MARKET	20.17	24.99	34.61	58.31	73.89	111.13	159.29
MARKET RATIO	57%	57%	60%	58%	73%	60%	68%

OVERALL MARKET RATIO WEIGHTED BY VOLUMES OF INSURANCE:

CDIP RATE	\$27.78
AVERAGE MARKET RATE	44.90
MARKET RATIO	62%

November 1, 1985

CDA RSP GROWTH

APPENDIX D

MONTH: DECEMBERPLAN YEAR 1985

	Column 1	Column 2	Column 3	
	Current Month	Year-to-Date 1985 (Mar-Dec)	Year-to-Date 1984 (Mar-Dec)	Increase (Decrease)
A. NEW ACCOUNTS	22	118	54	118%
B. <u>CONTRIBUTIONS</u> : (Dollars)				
1. Fixed Income	116,424.60	612,077.86	240,567.90	154%
2. Common Stock	150,878.33	558,608.23	206,883.35	170%
3. Money Market	122,681.26	911,819.11	489,829.18	87%
4. Balanced Fund	28,157.58	229,555.15	152,429.69	51%
5. Sub-Total	418,141.77	2,312,060.35	1,089,710.12	112%
Guaranteed Fund				
6. 1-Year	11,375.00	60,480.62	NEW	N/A
7. 2-Year	--	--	NEW	N/A
8. 3-Year	4,000.00	45,766.03	NEW	N/A
9. 4-Year	--	--	NEW	N/A
10. 5-Year	21,142.98	103,920.97	NEW	N/A
11. Sub-Total	36,517.98	210,167.62		N/A
12. TOTAL CONTRIBUTIONS (includes Transfers-in)	454,659.75	2,522,227.97	1,089,710.12	113%
C. <u>TRANSFERS-IN</u> :				
1. Number of Transfers	41	218	129	169%
2. Amount \$	266,118.48	1,570,717.29	695,225.73	126%
D. <u>DE-REGISTRATIONS</u> :				
1. Number of Accounts	5	70	110	(36%)
2. Amount \$	108,534.41	2,361,061.50	3,379,106.27	(30%)
E. <u>NET GAIN (LOSS)</u> :				
1. Number of Accounts	17	48	(56)	
2. Amount \$	346,125.34	* 161,166.47 *	(2,289,396.15)	
F. TOTAL # OF ACCOUNTS		1,452	1,217	20%

Comments: *OUT OF THE RED IN 10 MONTHS

- *16 annuities (including 3 RRIF's) - \$1,069,134.17
- *Number of Accounts to date increase - 118%
- *Contributions/Transfers to date, dollar increase - 131%
- *Number of Transfers to date increase - 169%
- *Transfers to date, dollar increase - 126%
- *Number of Deregistrations to date, decrease - 36%
- *Deregistrations to date, decrease - 30%

Note: Excluding annuities, deregistrations decreased - 56% in dollars

COUNCIL ON STUDENT AFFAIRS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Council Members: Miss Liliane LeSaux, Chairman, U. of Western Ontario
Mr. Bob Barr, U. of Manitoba
Dr. Dan Beck, Vancouver, B.C., Past Chairman
Mr. Gale Blischak, U. of Saskatchewan
Mr. Martin Bourgeois, Dalhousie U.
Mr. Norman Clement, McGill U.
Miss Joanne Collins, U. of Toronto
Mr. David Ciriani, U. of British Columbia
Mr. Tony DeLauri, U. Laval
Miss Mireille Homsy, U. de Montréal
Dr. Greg Lovely, Lockeport, N.S., Past Student Governor
Mr. Robert McCashew, U. of Alberta
Mr. Sam Sgro, McGill U., Student Governor
Miss Pam Zakarow, U. of Western Ontario

Executive Liaison: Dr. J.W. Niedermayer, Regina, Saskatchewan

1. Council Meetings

Council has met once since the last Board meeting, on October 26, 1985, in Toronto, immediately following the 1985 Canadian Dental Students' Conference.

Items Requiring Board Action

2. LTD Coverage for Senior Students

At the October CDA Board meeting, CDSPI proposed that Long Term Disability coverage be provided students upon completion of their penultimate year of dental school, for a 12-month period. (APPENDIX I)

This matter was reviewed and Council therefore recommends:

RESOLVED:

86.36 WHEREAS Canadian dental students have expressed a concern about the possibility of serious accident or injury during the course of their final dental years, and

COUNCIL ON STUDENT AFFAIRS

WHEREAS CDSPI has, upon the directive of the Council on Student Affairs, developed a proposal for LTD insurance in the year preceding graduation,

THAT the Council on Student Affairs recommend to CDSPI that LTD insurance be provided to CDA student members in good standing with eligibility for benefits commencing on the day following the termination of regular studies in the student's penultimate year. (It is assumed that regular does not include supplemental examinations and that coverage continues until receipt of the graduation package on graduation day.)

ADOPTED

To ensure that 1986 graduates benefit from this coverage, Council recommends:

RESOLVED:

86.37 THAT the LTD insurance be provided to current 1986 graduates who are CDA members in good standing with benefits commencing on January 1, 1986, and extending until receipt of the graduation package on graduation day.

ADOPTED

Since that time, we have learned from CDSPI that implementation of special coverage for 1986 graduates requires CDA approval.

Upon approval of the above motion, CDSPI will commence immediate implementation of this coverage for 1986 graduates.

2. Revisions to CDA's Practice Management Manual

Council reviewed the Manual as developed in 1983 under the direction of Dr. Bob Brandon. Due to the ever-changing and expanding nature of these materials, Council felt that the Manual should be revised and updated to keep current with new information in the field.

In order to begin this project, Council recommends:

COUNCIL ON STUDENT AFFAIRS

RESOLVED:

- 86.38 WHEREAS the Council on Student Affairs wishes to keep current the CDA Practice Management Manual,

THAT updated information shall be requested by CSA on a regular basis from each Canadian dental school in order to provide a reserve of current, pertinent materials related to those chapters which currently appear or may be added in future, to the Practice Management Manual, and may provide a future source of information to be utilized when a revision is deemed appropriate or necessary by the Committee members.

ADOPTED

Council expressed a desire that Dr. Brandon continue to be affiliated with this project and that he begin work on the revisions as soon as materials are available.

Items Not Requiring Board Action

3. Federal Tax on Certain Dental Health Care Products

Council expressed concern on the recent Federal Government's implementation of sales tax on certain dental health care products, and the possible ramifications of this on dental health care and patient education.

Therefore Council expresses to the CDA Board its support of CDA actions directed towards the Federal Government in this regard.

4. CDA Student Membership

For purposes of promoting student membership, it was decided that effective September 1986, personalized membership renewal forms and pertinent membership and insurance information be forwarded to all CDA student members, and that application forms and brochures be forwarded to all first time applicants and non-members.

In previous years, all students, members and non-members alike, received the same application and membership brochure. It is further noted that in September 1986, the CDA student membership fee will be raised by \$1.00 to \$14.00 per year. This is in keeping with a previous motion passed at the September 1983 CDA Board, indicating that the student fee be maintained at 6% of CDA's active membership fee.

COUNCIL ON STUDENT AFFAIRS

5. Manpower

Council expressed concern over the current manpower situation, and realizing CDA's ongoing commitment to this matter, wishes to provide any and all assistance deemed necessary in the event of further action on the issue.

6. CFDE

Council members feel that it is the responsibility of the profession to support the Fund, and would like to see this responsibility begin with students. CSA, therefore, through its representatives, will actively promote the CFDE at each school.

7. CDA/Dentsply Student Clinician Program

For the first time in eight years, a student competition was held in Ottawa at the 1985 CDA Convention.

First prize of a trip to San Francisco to attend and present his clinic at the American Dental Association Convention, was awarded to Mr. Peter Brawn of McGill University. Mr. Rob Bizley of the University of Western Ontario, was awarded a cash prize for his second place finish.

8. CSA Elections Results & Representation to Other Meetings

At the last meeting of Council, election to the positions of Governor-Elect and Chairman-Elect, occurred. Miss Pamela Zakarow, University of Western Ontario and Mr. Bob Barr, University of Manitoba, now hold these positions, respectively.

Representatives designated to attend other meetings are:

National Dental Examining Board of Canada - Mr. Sam Sgro

Association of Canadian Faculties of Dentistry - Mr. Sam Sgro

Council on Education and Accreditation - Dr. Dan Beck

Prelicensure Conference - Miss Liliane LeSaux and Dr. Dan Beck

CDA Board of Governors - Mr. Sam Sgro, Miss Liliane LeSaux, Miss Pamela Zakarow

COUNCIL ON STUDENT AFFAIRS

9. Canadian Dental Students' Conference 1986

The 1986 Canadian Dental Students' Conference is scheduled to be held in Halifax, Nova Scotia, from September 24-27, 1986.

Summary

On behalf of the Council on Student Affairs, I would like to express appreciation for the guidance, support and fellowship of our Executive Liaison, Dr. J.W. Niedermayer, who has now ended his term on Council.

I would also like to express the appreciation of not only the Council of Student Affairs, but of all Canadian dental students to the Canadian Dental Association for its ongoing support and interest in us, and the opportunities afforded us to participate in national dentistry.

Respectfully submitted

Liliane LeSaux
Chairman
Council on Student Affairs

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Student Affairs with appreciation.

APPENDIX I TO CSA REPORT



**Canadian
Dental
Service
Plans Inc.**

Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Metro Toronto
Telephone: 497-7117

Western Canada, Atlantic Canada,
Ontario Area Code 807
1-800-268-5418

Quebec and Ontario: Except Area Code 807
1-800-268-3411

January 7, 1986

Miss Linda Teteruck
Director of Educational Services
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Linda

When we looked at the administrative procedures that will be necessary to introduce the Student LTD program, we discovered that what was proposed to the CDA Board of Governors, and approved, differed from what we discussed at the October 26, 1985, meeting of the Student Council.

Specifically in question is Long Term Disability Insurance for 1986 graduates requested to be effective January 1, 1986, and to be maintained until the graduate insurance becomes effective. Also, how do we treat the student who fails his supplemental examinations?

If we are to proceed with the implementation of the Student LTD, as per the contents of your letter of November 27, 1985, we need written authorization from the Executive Council of the CDA. Will you bring this matter to their attention and obtain the necessary approval? I have discussed this whole matter with Kingsley, and we cannot process insurance coverage which has not been approved by the CDA.

I am enclosing a copy of a letter from our consultant, dated November 8, 1984. The presentation to the CDA Board of Governors was based on the contents of that letter, and you can see there is no reference to the two points I have mentioned.

Please accept my apologies for any inconvenience, and if you need further information, please give me a call.

Sincerely

gail
Cyril J. Gallant, CLU
Director of Plans

CJG/dcd

Encl.

TOWERS, PERRIN, FORSTER & CROSBY
250 BLOOR STREET EAST, SUITE 1100
TORONTO, ONTARIO M4W 3N3
(416) 960-2700

DIRECT DIAL

960-2706

Ref. No. 066.9/27

November 8, 1984

Mr. Kingsley D. Butler
General Manager
Canadian Dental Service Plans Inc.
Suite 600, 2 Lansing Square
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

Re: LTD for Students

This is with respect to the matters discussed in your letter of October 3, 1984 concerning this subject.

To our knowledge, there is not currently available a disability income benefit of this type. However, we believe that a soundly underwritten LTD benefit for dental students could be introduced to the Canadian Dentists' Insurance Program.

Following is an outline of the basic concepts of a proposed program:

1. Eligibility -- all dental students in Canada upon completion of third year of dental school, for a 12-month period thereafter.
2. Disability waiting period -- three months.
3. LTD Benefit -- \$500 per month for nine months; \$2,000 per month thereafter for four years.
4. Definition of Disability
 - (a) 1st year -- full disability if the individual is disabled to the extent that he/she cannot attend dental school and is not able to work at an occupation providing "reasonable" compensation (say, a job with income of more than \$1,000 per month). In this context, "cannot attend dental school" means that the person is not physically able to attend dental school, or a medical doctor has certified that the person should not pursue such studies because the person would not be physically able to pursue a dental career upon graduation. The dental school concerned would also certify that the individual has withdrawn from the program of studies.

TOWERS, PERRIN, FORSTER & CROSBY

To: Mr. Kingsley Butler
Page: Two
Date: November 8, 1984

- (b) thereafter -- full disability is same as in the first year, but the disabled person is also not able to pursue other academic studies. Partial disability benefits of \$500 per month would be paid during the time the individual is disabled with respect to dental school, but is able to pursue other academic studies.

5. Exclusions -- Pregnancy, other than complications; mental and nervous conditions other than psychotic conditions which necessitate treatment in a hospital or mental institution; other normal exclusions such as self-inflicted wounds.

We recommend that the LTD program be introduced on a no-cost packaged basis for all final-year students (i.e. same benefit schedule, disability waiting period and contractual provisions for all). Given the limited benefit period, the three month waiting period, and the various restrictions on entitlement for full benefits, the expected cost of such a program is low. We estimate that the annual expected cost or "premium" for this plan would be in the area of \$5,000 - \$10,000, based on current enrollment of approximately 400 final-year dental students in Canada.

Given the unknowns involved in introducing a new benefit such as this, we doubt that Imperial Life (or any other major underwriter) would want to insure this program on a pooled, or "stand-alone" basis. For this reason, we recommend that, if this program were to be introduced, the liability for claims incurred should be absorbed in the regular experience-rating account of the CDIP disability plan. Moreover, it is possible that Imperial Life could be persuaded to include this benefit feature without necessitating an explicit premium payment or an increase in the existing premium rate structure.

We have discussed these basic features of a student LTD benefit with Don Jarvis of Imperial. He felt that Imperial Life would not have any major objections to the introduction of the plan, given the relatively small liability involved.

Please let us know if the Management Committee is agreeable to the conceptual outline noted above. If they are so inclined, we could present the outline for Imperial Life's formal consideration. Provided the benefit features and underwriting considerations are acceptable to Imperial, a more fully documented proposal for this new benefit then could be presented to the CDSPI Board for its approval.

Yours truly,

TPF&C LIMITED


Kenneth T. Ransby

/cc

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

I. FUTURE MEETINGS

The ACFD/AFDC Fourteenth Biennial Conference on Canadian Dental Research and Education will be held at Nottawasaga Inn, Alliston, Ontario from June 10-13, 1986. In addition to the regular research and education programs, there will be a seminar on the subject "Getting Started in Clinically Applied Research", which will be held on June 8th and 9th.

We believe the entire program will be of interest to some practitioners, as well as academics. A copy of the program is attached to this report.

APPENDIX I

Our conference will be enhanced considerably through support from the Canadian Dental Association, which will provide subsidy for the attendance of one student representative from each of the dental schools. The program of the Education Committee, "Dental Education - Some Like It Not", promises to be interesting and, with student and staff participation, should lead to some interesting presentations and discussions.

II. SUMMER TEACHING INSTITUTE

The reports from academic staff members who were in attendance at the first Summer Teaching Institute have been most positive. Information gained through attendance at the first Institute has resulted in some new approaches and changes in teaching procedures and techniques.

The Institute is funded by the Canadian Fund for Dental Education, with support from each of the participating schools. The second Summer Teaching Institute will be held June 15 - 27, 1986, at the University of Western Ontario. Attached to this report is a brochure for the 1986 Institute.

APPENDIX II

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY

III.

At the Annual Conference of the Dental Licensing Authorities in Toronto, December 6, 1985, we discussed the feasibility of developing a national program for assessment and retraining of practitioners requiring and/or desiring same. This project will be considered by our Education Committee and should result in the development of a program which will be of benefit to the practitioner's requiring assistance and to the licensing bodies which have concerns regarding the availability of formal upgrading programs.

Respectfully submitted,

A. Schwartz, President

ADOPTION OF REPORT

The Report of the Association of Canadian Faculties of Dentistry received as information by the Board of Governors, with thanks.

ACFD/CADR XIV BIENNIAL CONFERENCE ON
CANADIAN DENTAL RESEARCH AND EDUCATION

JUNE 7-13, 1986

NOTTAWASAGA INN, ALLISTON, ONTARIO

APPENDIX I

SATURDAY JUNE 7	SUNDAY JUNE 8	MONDAY JUNE 9	TUESDAY JUNE 10	WEDNESDAY JUNE 11	THURSDAY JUNE 12	FRIDAY JUNE 13
ARRIVAL	- Research and Education Committee Meetings	- Getting Started in Clinically Applied Research (SESSION II)	- Applied Research for the Clinician in Dentistry (invited speakers)	- Educational Research and New Program	Oral Presentation of Abstracts (Research)	<u>HOUSE</u> <u>OF</u> <u>DELEGATES</u>
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	POSTER Presentations & LUNCH	LUNCH
OF COMMITTEE MEMBERS	Getting Started in Clinically Applied Research (SESSION I)	Getting Started in Clinically Applied Research (SESSION III)	Poster Presentations	Poster Presentations	Education "Dental School -Some Like It Not" (Workshop II)	<u>EXECUTIVE</u> <u>COUNCIL</u> <u>MEETING</u>
		Section Meetings	Education "Dental School -Some Like It Not." (Workshop I)	Oral Presentation of Abstracts (Research)	<u>HOUSE</u>	
			CADR Annual Meeting (5:00-6:00)		<u>OF</u>	
	<u>Executive</u> <u>Council</u> <u>Meeting</u> <u>MIXER</u>	<u>Executive</u> <u>Council</u> <u>Meeting</u>	-	 Cocktail Party * Bar-B.Q.	<u>DELEGATES</u>	
					* Conference Dinner	

8:00
9:00
to

11:00
12:00

LUNCH
12:00
-1:00

3:00
5:00

2:00

4:30

5:00

7:00

*8:00

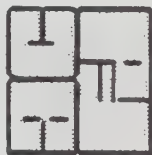
THE

ACFD

Summer Teaching Institute

June 15-27, 1986

University of Western Ontario



A PROJECT OF THE

EDUCATION COMMITTEE,

ASSOCIATION OF CANADIAN

FACULTIES OF DENTISTRY

sponsored by

THE CANADIAN FUND FOR

DENTAL EDUCATION

and

CANADIAN DENTAL FACULTIES

GOALS OF THE INSTITUTE

- To provide newly appointed dental educators with an overview of current teaching methods which apply to professional education
- To assist experienced dental educators in the assessment and improvement of their current teaching skills.

INSTITUTE FORMAT

A "hands-on" workshop approach will be used.

The program will consist of an intensive two-week learning experience which will include the following topics:

- planning your course
- choosing appropriate teaching methods for the classroom, lab and clinic
- one-on-one instruction methods
- micro-teaching
- evaluation of learning
- evaluation of teaching

SAMPLE DISCUSSION TOPICS

- can good teachers get promoted?
- why do we lecture?
- can good teaching techniques be learned?
- what are labs for?
- the lock-step curriculum - can learning survive?
- what do we test for?
- how valid is your testing?
- how reliable is your testing?

WHO SHOULD ENROLL?

The Institute will be of most interest to those faculty members who are willing to:

- critically evaluate the strengths and weaknesses of their own teaching;
- experiment with different teaching methods; and
- cooperate with others.

If you are interested in participating, contact your Dean for further information.

TIME, LOCATION AND ARRANGEMENTS

The Institute will be held on the campus at the University of Western Ontario. It will run from June 15-27, 1986.

Air fare and accommodations will be provided. Regretfully, due to the intensive nature of the program, families are not invited to accompany participants.

There will be ample time for recreational activities.

INSTITUTE FACULTY

Bruce Squires, M.D., Ph.D., Director
Health Sciences Educational Development
University of Western Ontario

Richard Lewis, Ph.D.
Department of Communication Studies
University of Windsor

John Eisner, D.D.S., Ph.D.
Faculty of Dentistry
Dalhousie University

FACULTY LIAISON

UBC - Dr. Bill Wood
Alberta - Dr. Ken Hinkelman
Saskatchewan - Dr. Linda Lee
Manitoba - Dr. Sam Borden
Western Ontario - Dr. Alan Mills
Toronto - Dr. Barry Korzen
Montreal - Dr. Pierre Desautels
McGill - Dr. Chris Clark
Laval - Dr. Marcel Proulx
Dalhousie - Dr. Bruce Graham

COMMENTS FROM THE 1985 INSTITUTE

"...it has made a large impact on what I am currently doing at our school."

"I can put many of these new ideas into practice in the very near future...the rest of our faculty can also benefit from the knowledge you passed on."

"I learned that other methods are more effective than the lecture method."

"...will go a long way to help me improve my teaching skills."

"I thought it was an excellent course. I am eager to employ some of these new techniques."

"I learned how to improve clinical evaluation, students' self-assessment and feedback."

"The more people that can be educated in these principles, the better the system will be."

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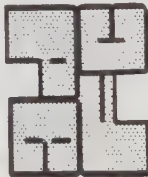
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Institut Pédagogique d'Été AFDC

15-27, juin 1986
Université Western en Ontario



ORGANISÉ PAR
LE COMITÉ DE PÉDAGOGIE,
ASSOCIATION DES FACULTÉS
CANADIENNES DE DENTISTERIE

subventionné par
LE FONDS CANADIEN
POUR L'ENSEIGNEMENT
DENTAIRE
ET

LES FACULTÉS CANADIENNES
DE CHIRURGIE DENTAIRE

OBJECTIFS DE L'INSTITUT

- présenter aux nouveaux enseignants en chirurgie dentaire un aperçu général des méthodes courantes d'enseignement qui s'appliquent à l'enseignement de la profession
- aider les enseignants expérimentés à évaluer et améliorer leur compétence pédagogique

FORMULE DE L'INSTITUT

L'Institut sera organisé selon la formule de participation active en ateliers.

Le programme consistera en deux semaines de formation intensive où seront abordés les sujets suivants:

- l'organisation d'un cours
- le choix de méthodes d'enseignements appropriées pour la salle de classe, le labo et la clinique
- les méthodes d'enseignement individuel
- le micro-enseignement
- le contrôle des connaissances
- l'évaluation de l'enseignement

EXEMPLES DE SUJETS À DISCUTER

- les bons enseignants peuvent-ils avoir de l'avancement?
- pourquoi donnons-nous des cours magistraux?
- peut-on acquérir de bonnes techniques d'enseignement?
- à quoi servent les labos?
- les programmes à étapes obligatoires - l'apprentissage peut-il survivre?
- que contrôlons-nous?
- dans quelle mesure nos contrôles sont-ils valides?
- dans quelle mesure sont-ils fiables?

À QUI L'INSTITUT EST-IL DESTINÉ?

L'Institut sera surtout profitable aux enseignants qui sont disposés

- a) à évaluer de façon critique les points forts et les points faibles de leur enseignement;
- b) à mettre à l'essai des méthodes d'enseignement diverses; et
- c) à coopérer avec les autres participants.

Si vous désirez vous inscrire, adressez-vous à votre Doyen pour obtenir de plus amples renseignements

DATES, LIEU ET DISPOSITIONS

L'Institut aura lieu au campus de l'Université Western en Ontario, de 15 au 27 juin 1986.

Les frais de voyage et de logement seront accordés aux participants. Vu la nature intensive du programme, les familles ne peuvent être invitées à accompagner les participants.

Les participants disposeront de temps libre pour se détendre.

PERSONNEL ENSEIGNANT

Bruce Squires, M.D., Ph.D., Director
Health Sciences Educational Development
University of Western Ontario

Richard Lewis, Ph.D.
Department of Communication Studies
University of Windsor

John Eisner, D.D.S., Ph.D.
Faculty of Dentistry
Dalhousie University

LIAISON

UBC - Dr. Bill Wood
Alberta - Dr. Ken Hinkelman
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Manitoba - Dr. Sam Borden
Western Ontario - Dr. Alan Mills
Toronto - Dr. Barry Korzen
Montréal - Dr. Pierre Desautels
McGill - Dr. Chris Clark
Laval - Dr. Marcel Proulx
Dalhousie - Dr. Bruce Graham

COMMENTAIRES DE L'INSTITUT DE 1985

"... cela a eu une forte impression sur ce que je fais actuellement à notre école."

"Je peux mettre en pratique plusieurs de ces nouvelles idées dans un avenir prochain. Je pense que notre faculté peut tirer profit des connaissances que vous nous avez transmises..."

"J'ai appris que d'autres méthodes sont plus efficaces que la méthode d'enseignement magistral"

"... cela devrait bien améliorer mes compétences en tant qu'enseignant."

"J'ai pensé que c'était un cours excellent. J'ai hâte d'employer certaines de ces nouvelles techniques"

"J'ai appris comment améliorer l'évaluation objective, le feedback et l'auto-évaluation des étudiants."

"Plus il y aura de gens éduqués selon ces principes, meilleur sera le système."

CANADIAN FUND FOR DENTAL EDUCATION

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

1. I was greatly pleased to learn that the CDA Governors, at their October 1985 meeting, approved my appointment as Chairman of CFDE's Board of Trustees. It will be an honour and a privilege to serve in this capacity and I will do my utmost to be a worthy successor to those who preceded me in this office and who played such a vital part in the development of the Fund. My special thanks go to Dr. David Peters, my immediate predecessor, for his capable leadership during the past three years.
2. It is with much pleasure then that I provide you with my first report on the activities of the Canadian Fund for Dental Education.

1985 INCOME

3. Our records for 1985 have now been closed off and, although the auditors' statements are understandably not as yet available, I am confident the following information is correct and will not be changed in any way.
4. Total income from all sources reached a high of over \$300,000 (\$300,532) which is 6.7% more than in 1984. Operational income was \$290,432, a new record total and \$8,818 more than in the previous year. Endowment fund gifts totalled \$10,100.
5. You will recall that in 1984 dentists' personal gifts to our general fund were the largest single source of income reaching a high of \$91,499. I am pleased to let you know that in 1985 dentists maintained their leadership with an almost identical total of \$91,423 in personal gifts to help advance their profession.

CANADIAN FUND FOR DENTAL EDUCATION

6. Donations from dental organizations (\$25,639) and business & industry (\$75,795) recorded slight decreases of 3% and 2% respectively. Gifts from dental organizations were affected by the absence of a \$10,000 gift received in 1984 which, I am pleased to say, was largely offset by CDA's significant increase in support last year. The reduction in donation income from business & industry is primarily due to the withdrawal of the corporate sponsorship for the CDA Students' Conference in 1985, and despite numerous efforts on our part, no gift at all was received from the company last year.
7. As expected, gifts to our living memorial fund decreased considerably in 1985 reaching a high of \$11,510. You will recall that the 1984 total of \$19,530 was greatly influenced by the many gifts received in Mr. McDonald's memory as well as a special memorial gift of over \$2,000.
8. Areas that recorded substantial increases over the previous year are investment income at \$62,720 (up \$4,301), sundry income at \$20,747 (up \$14,343) and tribute gifts at \$1,323 (up \$902). The reason for the large increase in sundry income is that several dentists and dental hygienists, who were asked for repayment of their fellowship awards, elected to repay their indebtedness in full last year.
9. As mentioned above, \$10,100 was received in endowment fund gifts in 1985, \$100 to be added to the Murray McDonald endowment fund and \$10,000 in the form of a bequest from Mrs. George W. Barrett towards the living memorial fund in her husband's name which had been established with CFDE.

1985 DISBURSEMENTS / GRANTS

10. The CFDE Trustees, at their annual meeting last April, approved grants totalling \$210,055 for 1985 and Dr. Peters provided you with details on the many programs supported in his report last October.
11. I am now pleased to let you know that several additional grants were approved subsequent to the annual meeting and that the total expended for educational and research projects in 1985 reached an unprecedented high of \$226,206. This is \$60,067, or 36.1%, more than the previous year.

CANADIAN FUND FOR DENTAL EDUCATION

12. The grants approved later in the year were in support of RCDC's Symposium on Facial Pain, a Dental Auxiliary Educators Meeting, the Periodontal Post-Graduate Program at the University of Toronto and an additional half fellowship.

1985 DISBURSEMENTS / OPERATING EXPENSES

13. It is most gratifying to report that 1985 operating expenses of \$96,720 have virtually remained at the same level as those for the previous year, showing an increase of less than one half of one percent only.
14. As indicated above, grants for 1985 totalled \$226,206 and expenses in connection with them were \$18,772.
15. Management and fund raising expenses in 1985 as a percentage of total income amounted to 25.9%, a reduction of 1.4% from the 1984 figure of 27.3%.

MANAGEMENT COMMITTEE MEETING

16. Since reporting to you last fall, a CFDE Management Committee meeting was held on November 29, 1985.
17. The agenda included a review of the reports received from the four schools benefiting from the Lorne E. MacLachlan Endowment Fund, consideration of a report submitted by the Murray McDonald Memorial Lecture Committee, a progress report from Dr. John Eisner (who personally attended the CFDE meeting) on the ACFD Summer Teaching Institute as well as several grant requests.
18. You will be pleased to learn that the Committee approved a \$10,000 grant in support of the XIVth Biennial Conference on Dental Education and Research scheduled for June 8-14, 1986, a grant of \$5,000 in support of ODA's Computerized Dental Check-Up Project and gave approval in principle to CDHA's Continuing Education Conference "Let's ALL Learn" (scheduled for August 1986 in Halifax) with a final decision as to the financial support available to be made at CFDE's 1986 annual meeting.

CANADIAN FUND FOR DENTAL EDUCATION

APPRECIATION

19. CFDE's accomplishments last year would not have been possible without the help of all those who so generously assisted our efforts. To each and everyone of them I wish to express, on behalf of my fellow Trustees and myself, sincere appreciation.
20. I acknowledge, with gratitude, the continued splendid cooperation and support CFDE was privileged to receive from the National and Provincial Dental Associations. Their financial assistance is obviously of inestimable value to the Fund's ongoing progress, but I would also like to say a word of thanks for the various other ways in which they so generously and effectively help our efforts, e.g. through the fine coverage they give us in the pages of their publications.
21. In his last report to you Dr. Peters expressed the Trustees' grateful appreciation for CDA's substantially increased financial support in 1985. I would like to reiterate our thanks at this point and couple them with the hope that we can look forward to your continued generosity in 1986.

Respectfully submitted,

J. Fred Reid, D.D.S.
Chairman
CFDE Board of Trustees

ADOPTION OF REPORT

The Report of the Canadian Fund for Dental Education received as information by the Board of Governors, with thanks.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

The National Dental Examining Board of Canada continued the process of periodic review of its functions in 1985 by holding a Workshop on Preclinical and Clinical examinations. The first part of this review process was the Study on Accreditation completed in 1983.

In its role as a regulatory agency and in accordance with licensing authority directives, the NDEB is at all times cognizant of its mandate to certify only those candidates who have proven that they can practise dentistry with competence in Canada.

I CERTIFICATION MECHANISMS

1. Current Graduates Statistics - Appendix I

The Board reviewed the current graduate certification process and agreed that it recognizes the examinations and evaluation administered by Canadian faculties of dentistry approved by the CDA Council on Education and Accreditation for the purpose of certification examination.

The Board further agreed that its commitment to the accreditation process and to the present policy of current graduate certification remains strong.

2. Examinations

Examination statistics appear in **Appendix II**

As a result of recommendations made at the Workshop on Preclinical and Clinical examinations, Board examinations have been changed as follows effective January 1, 1986:

- Preclinical examination becomes
Clinical Examination Part A;
- Clinical examination becomes
Clinical Examination Parts B & C.

.../2

The clinical examination content and time allowances appear in **Appendix III**.

Candidates will be permitted to utilize commercial laboratories for Part C if they so wish.

Candidates who are eligible to retake the clinical examination at present will be required to take and be successful in Parts B & C of the clinical examination in 1986 in order to be certified by the Board.

The Board felt that the proposed examination structure and content will be more effective in determining the basic clinical competence of a candidate and the successful completion of clinical examination. Parts A & B should be more of a justification for admitting a candidate to the final or invasive stage of the examination (Part C).

The Board is implementing its responsibility to establish and administer examinations which are fair, reliable and representative of the practice of dentistry in Canada.

The Board also approved Regulations for Selection of Clinical Examiners to be forwarded to provincial licensing authorities as follows:

- a) Must be licensed and active in the clinical practice of dentistry in a province in Canada.
- b) Must have considerable clinical experience in Diagnosis and Treatment Planning, Restorative Dentistry, Periodontics and Prosthodontics.
- c) Must have demonstrated capability in evaluation procedures in the disciplines mentioned in Item 2.

All names forwarded to the Board must be accompanied by an experiential resumé.

II BY-LAWS

The Board approved an addition to present By-laws as follows:

- 8.02 An applicant for certification is to be considered examination ineligible if sufficient evidence is available to the Board that the applicant's licence to practice is suspended or cancelled, or the candidate is on probation within his licensing jurisdiction; examination eligibility may be restored should such conditions be removed.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

III CDA COUNCIL ON EDUCATION AND ACCREDITATION

1. Presentation by Mr. B. Henderson, CDA Director of Accreditation

Mr. Henderson drew the Board's attention to the pilot project which had been carried out last year as part of the accreditation process. This pilot had attempted to introduce the evaluation of the product into the accreditation process.

2. Address by Mr. J. Neilson, CDA Executive Director

Mr. Neilson relayed regrets from the CDA President who had also been invited to address the Board.

Mr. Neilson stated that in the view of the CDA, the NDEB is a very important member of organized dentistry and the CDA appreciates the difficult role that the NDEB plays in competence assessment.

Mr. Neilson also mentioned that the Executive Council of the CDA wishes to further promote cooperation and understanding between all dental organizations.

3. Pre-Licensure

The Chairman of the CDA Ad Hoc Committee on Mandatory Pre-Licensure, Dr. G.S. Beagrie, stated that the forthcoming conference was jointly sponsored by the CDA, NDEB, and CFDE.

4. CDA/ADA Reciprocity

The Chairman of the CDA/ADA Ad Hoc Committee on Reciprocity, Dr. A. Schwartz, brought the Board members up to date on this issue.

5. Continuing Education

The Board appropriated its share to support the Self-assessment/Education pilot project, but not to exceed \$10,000.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

IV NDEB/RCDC

The Board noted, with regret, the absence of the RCDC President, who traditionally has been invited to attend this portion of the meeting.

The NDEB representative to RCDC stated that the present Regulations governing NDEB/RCDC certification have been a cause of concern for some time.

For the benefit of new Board members the Registrar gave the historical background of the two organizations as follows:

1. The NDEB was incorporated in 1952 and the RCDC in 1965.
2. In 1971, the RCDC approached the NDEB to offer its services as an examining facility in order to assist the licensing authorities in establishing qualifications of specialists.
3. In 1973, the NDEB Act of Parliament was amended to include the responsibility for specialist certification, subject to the approval of the RCDC. This process took two years and cost the NDEB a considerable amount of money.
4. The 1973 Act states that the NDEB is the legal certifying authority and the RCDC is the examining facility for specialists.
5. In 1974, the NDEB and the RCDC began final negotiations in order to establish Regulations for obtaining the NDEB/RCDC certificate. These Regulations were completed in 1975 and have been amended several times.
6. An integral part of the negotiations for the Regulations was the type of examination that would serve the purposes of NDEB/RCDC certification. The RCDC proposed the RCDC Part I examination, which at that time was a written basic sciences examination.

The NDEB felt that the Part I examination was not adequate to meet the needs of the licensing authorities for the purpose of establishing the clinical competence of a specialist.

NATIONAL DENTAL EXAMINING BOARD OF CANADA

7. After lengthy negotiations, the RCDC agreed to add an oral examination to the Part I examination. This oral examination was to be specifically directed to establish a candidate's clinical knowledge in his specialty and would include the use of models, photographs and radiographs.
8. Specialists licensed and practising in a province and not Fellows of the RCDC were offered a once-only examination in 1978 in order to obtain the NDEB/RCDC certificate.
9. In 1980, the RCDC established a membership category based on the successful completion of the new Part I examination which subsequently was to be known as the membership examination. Members of the RCDC would also be eligible for the NDEB/RCDC certificate.

The Board directed the NDEB representative to the RCDC to pursue and clarify the NDEB/RCDC certification process and report back in 1986.

V STUDENTS

The observer from the CDA Council on Student Affairs presented a report and stressed the excellent relationship that exists between the two organizations.

VI FINANCES

The Board ended the 1984/85 fiscal year with a surplus, however, this surplus was almost equal to the loss in 1983/84.

The Board's legal expenditures have been increasing at an alarming rate in the past few years. The Board anticipates the legal costs to reach 10% of total expenditures in 1985/86. Accordingly, certification fees have been increased by approximately 10% for 1986.

VII OFFICERS OF THE BOARD FOR 1986

President	Drs. R.B. Gilliland
Vice-President	H.M. Dick
Past-President	W.J. O'Driscoll
Registrar	G. Kravis
Administrative Officer/Treasurer	Mrs. F. Dawes

NATIONAL DENTAL EXAMINING BOARD OF CANADA

VIII CERTIFICATE OF MERIT

A Certificate of merit was presented to Dr. E.R. Ambrose who was completing his term as Chairman of the Written Examination Committee.

IX FUTURE MEETING AND EXAMINATION DATES - 1986

Annual Meeting	-	November 24 & 25
Executive Committee	-	April 6 & November 23

EXAMINATION DATES

Written		May 12, 13 & 14	*
Clinical	Part A	May 20, 21 & 22 (a.m.)	Montreal
	Part B	May 23, 26 & 27 (a.m.)	Montreal
	Part C	May 27 (p.m.), 28 & 29	Montreal
Clinical	Part A	August 5, 6 & 7 (a.m.)	Vancouver
	Part B	August 8, 11 & 12 (a.m.)	Vancouver
	Part C	August 12 (p.m.), 13 & 14	Vancouver
Written		October 20, 21 & 22	*
Clinical	Part C	December 18, 19 & 20 (a.m.)	Montreal

* selected university centres

Prepared by

G. Kravis, D.D.S.
Registrar

November 1985

ADOPTION OF REPORT

The Report of the National Dental Examining Board of Canada received as information by the Board of Governors, with thanks.

NDEB CERTIFICATES

issued to

CURRENT GRADUATES WITHOUT EXAMINATION

FACULTY	1971		1972		1973		1974		1975		1976		1977		1978	
	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.	# of Grad.	NDEB Cert.
ALTA.	47	47	51	51	38	38	50	50	45	45	42	42	39	39	51	50
B.C.	19	18	28	28	34	34	36	36	38	38	35	35	36	36	38	38
DALH.	22	22	23	23	24	24	30	29	22	22	29	29	29	29	26	26
LAVAL	-	-	-	-	-	-	-	-	10	10	16	14	7	7	14	14
MAN.	28	28	24	24	26	25	30	30	28	28	26	26	26	26	25	25
MCGILL	38	38	35	35	38	38	37	37	42	42	40	40	40	40	42	40
MTL.	74	67	67	66	78	73	79	72	77	51	78	76	77	67	79	78
SASK.	-	-	10	10	-	-	9	9	10	10	15	15	11	11	10	9
TORONTO	131	97	124	100	125	119	127	112	118	114	123	115	130	119	126	122
U.W.O.	10	10	30	30	34	34	52	52	43	43	50	50	53	53	56	55
TOTAL	369	327	392	367	397	385	450	427	433	403	454	442	448	427	467	457

NDEB CERTIFICATES

issued to

CURRENT GRADUATES WITHOUT EXAMINATION

FACULTY	1979			1980			1981			1982			1983			1984			1985		
	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.	# of Grad.	NDEB Cert.	NDEB Cert.
ALTA.	46	46	45	45	43	43	49	49	49	48	48	48	47	47	47	43	43	43			
B.C.	41	41	36	36	39	39	37	37	37	42	41	41	38	38	38	39	39	39			
DALH.	24	24	25	25	26	26	27	27	27	26	26	26	23	23	23	33	33	33			
LAVAL	23	22	24	24	23	23	19	19	19	21	19	19	23	23	23	30	29	29			
MAN.	28	28	32	32	27	27	27	27	27	36	36	36	23	23	23	22	22	22			
McGILL	43	43	37	37	42	42	37	37	37	37	35	35	36	35	35	40	39	39			
MTL.	81	79	80	77	84	80	82	80	80	78	74	74	74	72	72	74	71	71			
SASK.	13	13	20	20	19	19	19	19	19	22	22	22	23	23	23	21	21	21			
TORONTO	125	116	132	124	120	113	127	120	120	123	121	121	117	107	107	118	108	108			
U.W.O.	48	48	58	58	54	54	50	50	50	53	53	53	54	54	54	54	54	54			
TOTAL	472	460	489	478	477	466	474	465	465	486	475	475	458	445	445	474	459	459			

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - UNAPPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		PRECLINICAL		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1971	41	54	22	91	20	20
May 1972	44	59	26	69	27	33
May 1973 Oct 1973	42 7	48 29	23	78	25	32
May 1974 Oct 1974	35 11	69 30	27	85	37	43
May 1975 Nov 1975	51 28	63 57	35	74	28	39
May 1976 Nov 1976	61 30	62 63	46	54	48	33
May 1977 Aug 1977 Oct 1977 Dec 1977	59 34	63 44	64	55	36 29 4	53 48 75
May 1978 Aug 1978 Oct 1978	52 28	65 64	63	54	27 21	48 33
May 1979 Aug 1979 Oct 1979	38 27	68 59	71	38	32 17	31 37
May 1980 Aug 1980 Oct 1980	53 41	64 51	49 31	45 52	39 20	31 25
May 1981 Aug 1981 Oct 1981 Dec 1981	55 40	69 40	56 29	48 41	42 22 7	33 36 0
			371			

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - UNAPPROVED SCHOOLS

[illegible]

APPENDIX II

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

EXAMINATION DATA - APPROVED SCHOOLS

EXAMINATION SESSION	WRITTEN		CLINICAL	
	# of Candidates	% Succ.	# of Candidates	% Succ.
May 1971	32	63	-	-
Oct 1971	2	100	-	-
May 1972	47	87	-	-
Sept 1972	4	75	-	-
May 1973	30	80	-	-
Oct 1973	12	92	-	-
May 1974	38	95	-	-
Oct 1974	15	87	-	-
May 1975	31	90	-	-
Nov 1975	20	95	-	-
May 1976	36	92	-	-
Nov 1976	26	92	-	-
May 1977	56	91	-	-
Oct 1977	36	86	-	-
May 1978	26	92	-	-
Oct 1978	48	92	-	-
May 1979	9	100	3	33
Aug 1979			2	50
Oct 1979	13	92		
May 1980	23	100	11	27
Aug 1980			4	50
Oct 1980	14	100		
May 1981	12	100	8	25
Aug 1981			8	25
Oct 1981	4	100		

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

CLINICAL EXAMINATION CONTENT

PART A - 2 1/2 days

- I Diagnosis, Treatment Plan and Design for Removable Partial
Dentures from a dental and medical history, diagnostic casts
and radiographs.
Time: 1 1/2 hours

- II On articulated ivory teeth, mounted in manikins, the
candidate is required to perform on specified teeth five
NDEB selected procedures from the following:

- 1) Class II inlay - full restoration
- 2) Class II onlay - full restoration
- 3) Class II amalgam - full restoration
- 4) 3/4 crown-preparation only
- 5) full crown-preparation only
- 6) porcelain jacket - preparation only
- 7) porcelain fused to metal crown - preparation only
- 8) pin amalgam - full restoration
- 9) Class IV composite - full restoration

PART B - 2 1/2 days

I DIAGNOSIS AND TREATMENT PLANNING

1. Oral Medicine/Pathology

This slide examination evaluates the candidate's ability to recognize and diagnose oral pathological conditions from pertinent information provided.

Time: 1/2 hour

2. Periodontics - Diagnosis

This examination evaluates the candidate's ability to diagnose periodontal conditions and to formulate a sequence of treatment plans.

Time: 1 hour

3. Radiographic Interpretation

This examination evaluates the candidate's ability to interpret dental health and disease from a series of radiographs.

Time: 1/2 hour

4. Written Diagnosis & Treatment Plan

This examination evaluates the candidate's ability to formulate a diagnosis and treatment plan for a given case, from history, diagnostic casts and radiographs.

Time: 1 hour

5. Clinical Judgement - Current Considerations

Time: 1 hour

PART B (contd)

II PROSTHETICS & MASTICATORY PHYSIOLOGY

In the clinical setting with a patient present, this examination will evaluate the candidate's ability in the following areas:

1. Final Impressions
2. Jaw Registrations
3. Transfer of Registrations
4. Fabrication of maxillary and mandibular dentures for the try-in stage
5. Try-in (ready for processing)

PART C - 2 1/2 days

I RESTORATIVE DENTISTRY & RADIOLOGY TECHNIQUE

1. Class II Amalgam
2. Class V Composite
3. One restoration selected by the candidate from the following:
 - a) Full Crown - cast gold
 - b) 3/4 Crown - cast gold
 - c) Inlay Class II - cast gold
 - d) Onlay Class II - cast gold
 - e) Gold Foil Class II, III, IV, V
4. Radiology technique - four films.

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA REPORT TO CDA

Modern communications technology makes it possible for each of us to be aware of the significant events in other parts of the world. As we develop an awareness of our human partners in the world-wide community we find increasingly that our problems cannot be solved in isolation of each other, and must not be solved at the expense of the other.

Similarly, the dental profession in Canada has evolved into a complex community which must deal with a wide range of responsibilities if it is to continue its growth and development. It is appropriate that there be a division of labor so that the job can get done. The challenge is to ensure that each of the councils, boards and committees which serves organized dentistry in Canada work towards meeting shared objectives.

One of the very early objectives of the CDA was to establish qualifying conditions for a national standard certificate which would be recognized by all provinces for purposes of licensing to practice dentistry. This was the mandate of the Dominion Dental Council established by the CDA in 1906, and later renamed the Dental Council of Canada.

As the stated objective of the CDA in this matter was not being achieved, the CDA Council on Education in 1951 met with representatives of the provincial licensing authorities in order to further pursue the development of an examination/certification process which would be recognized by all provinces in Canada. This meeting resulted in the incorporation of The National Dental Examining Board of Canada in 1952, whose purpose has been to determine a standard of professional competence acceptable to the provincial licensing authorities and to issue its certificate to dentists who have demonstrated compliance with that standard. To date approximately 9600 NDEB certificates have been issued. The NDEB certificate is a requirement for licensure in all provinces for out-of-province graduates, indicating that the original CDA objective has been realized. The NDEB is justly proud of this accomplishment.

In the context of the changing pattern of dental disease in North America and the concurrent change in dental education, the continuing challenge for NDEB is to ensure that the examination/certification process continues to reflect current knowledge and professional practice. This requires that periodic in-depth reviews of these processes be undertaken; this was the basis for The Board's recent formal review of the accreditation process, as well as the examination workshop which was held last Spring. Brief comments about each of these follow.

The Board's mandate is to issue certificates only on the basis of demonstrated competence to practice dentistry. Current graduates of accredited Canadian dentistry programs qualify for the NDEB certificate on the basis of the evaluations/assessments used in the dental schools from which they graduate. In essence, the NDEB accepts the faculty evaluations in lieu of its own examinations for purposes of certification. This is justifiable as long as the Board is satisfied that the qualifying conditions for the DDS/DMD degree demand a standard of competence equivalent to the standard required of candidates who earn the certificate through the NDEB examination process. For this reason the Board feels that it must be a full participant in the accreditation process, and from time-to-time satisfy itself that the process continues to meet certification requirements.

The high failure rate in the clinical examinations and increasing examiner concerns over the number of grossly incompetent candidates who were reaching the clinical examination level prompted the NDEB to organize a two-day workshop last May for the purpose of a thorough review of the clinical examination. The outcome of the workshop was a recommendation that the preclinical examination become sufficiently rigorous to ensure that candidates who proceed to the clinical component of the examination do not place their patients at undue risk. In response to this recommendation, a significant restructuring of the examinations has occurred.

The following represent other important developments in Canadian dentistry in which the NDEB is involved:

1. The NDEB mandate for certification goes to the very core of the complex issues of initial competency assessment and continuing competency assurance of the practicing dentist. It is therefore appropriate that the NDEB is represented on the CDA ad hoc committees developing concepts relative to "prelicensure" and "self assessment". As you know, the NDEB was one of the sponsors of the Prelicensure Conference which took place in Montreal on February 24 and 25. The self-assessment pilot project is well advanced in the planning stages. Whatever the final outcomes of these ventures, it is significant that the CDA is sufficiently forward-looking to recognize the importance of exploring new ways of ensuring the continuing competence of dentists in Canada.

2. For the past year the RCDC and the NDEB have been reviewing their shared responsibility for examination and certification of dental specialists. The current NDEB/RCDC Specialist Certificate Regulations are problematic and are being reviewed. Additionally, because provincial licensing authorities generally accept the MRCD and FRCD qualifications for purposes of specialist certification, the NDEB/RCDC Certificate has become essentially redundant. On the surface, abandoning the certificate seems a logical solution, and is the one proposed by the RCDC. This approach, however, may contradict the requirements of the Acts of Incorporation of both the RCDC and the NDEB. Also, as the provincial licensing authorities are currently represented in the examination/certification process by virtue of their membership on the NDEB, the provinces will need to express their views in this matter. The CDA Council may also wish to influence the eventual resolution of this important issue.

3. Several items pertaining to administrative matters:

Although the financial position of the NDEB remains strong, currently approximately 10% of the budget is designated to legal fees in support of litigations initiated by failing examination candidates. Potentially, this problem may contribute significantly to increased examination fees.

The office has moved to a larger and more suitable suite of offices in the same building on Bronson Avenue. An invitation is extended to visit the Board at its new location.

The NDEB is fortunate to have a highly competent, dedicated and hard-working staff who deserve much of the credit for the past and continuing success of The Board. In order to meet the challenges of the future, we will continue to need people with vision and commitment, both on The Board and in the CDA. We are confident that this will happen.

Respectfully submitted,

H.M. Dick, D.D.S.
Vice-President
The National Dental Examining Board of Canada

APRIL 1986

ROYAL COLLEGE OF DENTISTS OF CANADA

REPORT TO THE 1986 INTERIM BOARD OF GOVERNORS, CDA

The College was pleased to hold its Annual Meeting, Convocation and Symposium in conjunction with the CDA Convention in September, 1985. We would specifically like to thank Dr. John J. Hardie, Scientific Program Committee Chairman, for his thoughtful attention to our needs for the Symposium on Facial Pain. It was also a happy coincidence that Dr. Hardie was admitted to the College as a Fellow in Oral Pathology in the midst of all his other activities on September 28th.

The Annual Meeting of the Council of the College was held on September 27th, at which time I officially assumed the office of President. As most of you know I had previously been filling the unexpired term of our late Past President, Dr. Jack Paynter. Dr. Rod Moran, previously a Councillor representing the Paedodontic section, and a former CDA President, was elected Vice President. Both terms are for the period 1985-87.

Newly elected Councillors for the three-year term 1985-88 are Dr. Roger L. Ellis, Dental Public Health; Dr. Pierre R. Dow, Endodontics, and Dr. R. John McComb, Oral Pathology. Dr. W. Fleming, Dental Sciences, and Dr. Aaron Fenton, Prosthodontics, were re-elected by acclamation for a second term. There is now a vacancy on Council in Paedodontics, and the nomination procedure will be in effect until January 31, 1986.

The current Council of the RCDC is as follows:

M.J. Crompton	President	Moncton, N.B.
R.L. Moran	Vice President	Toronto
J.H.P. Main	Past President	Toronto
K.C. Titley	Examiner-in-Chief	Toronto
J.E. Speck	Registrar	Toronto
R.L. Ellis	Public Health	Edmonton
W.J. Fleming	Dental Sciences	Toronto
P.R. Dow	Endodontics	Vancouver
G. Maranda	Oral and Maxillo-facial Surgery	Quebec
S. Weinberg	" "	Toronto
R.J. McComb	Oral Pathology	Toronto
C.G. Baker	Oral Radiology	Edmonton
C. Baril	Orthodontics	Montreal
J.S. Little	" "	Edmonton
A.N. Winnick	Periodontics	Toronto
A.H. Fenton	Prosthodontics	Toronto

ROYAL COLLEGE OF DENTISTS OF CANADA

At the Convocation on September 28th, held at the National Arts Center, 8 Fellows and 62 Members were admitted to the College. Honorary Fellowships were conferred on Dr. Jens J. Pindborg, Copenhagen, and Dr. Fred A. Henny, Michigan, and another Honorary Fellow, Dr. Wesley J. Dunn, gave the Convocation address. The ceremony was followed by a very successful Annual Dinner, where nine Past Presidents of the College were honoured to commemorate the College's 20th anniversary.

The biennial Symposium was held on September 30th, under the Chairmanship of Dr. Ken Bentley, on the general subject of Facial Pain, and given as part of the scientific program of the CDA Convention. It was very well attended, and I think could be considered an unqualified success.

There are presently 351 active Fellows and 285 Members in the College, and the numbers of applicants for the College examinations remain constant. We are very grateful that so many prominent specialists in the country are willing to give freely of their time and efforts to act as examiners. The College is not yet financially strong enough to be able to provide an honorarium for its examiners, so that the preparation and time they donate is truly in selfless support of the College's primary function.

The Council of the College has given approval to a proposal by the Examiner-in-Chief, Dr. Keith Titley, that both Membership and Fellowship examinations be held twice a year instead of once, and this will be effective in 1986. The written Membership Examinations will be held in May and October, and the oral component will be held six weeks or so later, at the same time as the Fellowship Examinations, in June and December. This will obviate the need for supplemental examinations, and we hope it will not only prove a benefit to candidates, but also to the licensing bodies, some of whom require the Membership Examination for the specialty certification.

The College looks forward to meeting with the CDA again in August in Halifax.

Respectfully submitted,

MICHAEL J. CRIPTON,
President

January, 1986

ADOPTION OF REPORT

The Report of the Royal College of Dentists of Canada received as information by the Board of Governors, with thanks.

ASSOCIATION OF PROSTHODONTISTS OF CANADA

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

The annual meeting of the Association of Prosthodontists of Canada was held September 29, 30, and October 1, 1985, at the Four Seasons Hotel in Ottawa, Ontario. Fifty members of the Association were in attendance.

Stimulating Scientific Sessions included presentations by Dr. Norman Schaaf, Buffalo, New York, on Maxillofacial Prosthetic Reconstruction, Dr. Arnold S. T. Franks, England, on The Future of Prosthodontics, and Dr. Douglas Deporter, on The Biological Pre-requisites for Success in Periodontal Therapy.

The second day of the program included presentations by Dr. John Houston, Toronto, on Resilient Denture Liners, Dr. John Cox, Ottawa, on A Five Year Longitudinal Clinical Study of Osseointegrated Implants. In addition, Dr. Len Boksman presented the current research evidence for The Efficacy of Posterior Composite Resin Restorations.

At its Executive Council and annual member meetings, the Association of Prosthodontists of Canada reaffirmed its commitment to the support of the Federation of Prosthodontic Organizations.

In the report of its standing committees of APC, the Continuing Education Committee reported on its investigation of continuing education courses offered in Canada on the subjects of Temporomandibular Joint Dysfunction and Implantology Dentistry. Arising from their report, the Executive Council directed the Continuing Education Committee to approach the Canadian Dental Association to offer advisory services for the development of guidelines for continuing education courses in the subject areas of Temporomandibular Joint Dysfunction and Dental Implantology. This recommendation results from considerable concern about the quality of various courses presented in these subject areas.

The Association of Prosthodontists of Canada noted with sadness the passing of Dr. Lorne E. MacLachlan, a long-time benefactor of prosthodontics in Canada. The Association wishes to thank the Canadian Dental Association for its awarding of an honorary membership in the Canadian Dental Association, posthumously, to Dr. MacLachlan on September 30, 1985. Canadian Dentistry has indeed lost an outstanding colleague.

ASSOCIATION OF PROSTHODONTISTS OF CANADA

During its annual meeting, considerable discussion amongst Association of Prosthodontists of Canada members focused on the desirability of more complete integration of the annual Scientific Session of APC into the Canadian Dental Association Program. On those years when APC is meeting in parallel with the CDA, it will be highly beneficial to have the Scientific Sessions of each organization joint and open to members of both organizations. For example, in 1985 Dr. George Zarb spoke to the Canadian Dental Association Convention's Scientific Session. It would have been mutually beneficial, APC believes, to have had this presentation as a joint APC/CDA venture.

Dr. Brock Love, the new President of APC, has undertaken an ad-hoc committee study of the future format and content of APC meetings and the possibility of greater integration of APC and CDA meetings, at least on a semi-annual or tri-annual basis, will be seriously considered.

The slate of officers for 1986, elected by the annual meeting is:

President:	Dr. Brock Love, Manitoba
President-Elect:	Dr. Robert Hoar, Halifax
Secretary-Treasurer:	Dr. Bruce Graham, Halifax
Vice President:	Dr. Hebert Gaucher, St. Foy, Quebec
Executive Councillors:	Dr. Pierre Helie, Montreal
	Dr. Michael MacEntee, Vancouver
	Dr. Ken Sutherland, Saskatoon
	Dr. Don Kramer, Toronto

Membership in the Association of Prosthodontists of Canada, at December 31, 1985, was 108.

Respectfully submitted,

Bruce S. Graham
Secretary-Treasurer

ADOPTION OF REPORT

The Report of the Association of Prosthodontists of Canada received as information by the Board of Governors, with thanks.

CANADIAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

The CAOMS executive met in October 1985 for our interim executive meeting. In addition to routine housekeeping matters, the executive dealt with strategic items of importance to the future of oral and maxillofacial surgery in Canada. Examples of future planning consist of establishing a standing committee to deal with the economics of practice; promote legislation to allow dentists with necessary expertise and qualifications to perform hospital admission history and physicals; providing "seedmoney" to allow Canada to host the International Association of Oral and Maxillofacial Surgeons meeting in Vancouver in May 1986; raise our annual membership dues to reflect the added costs of conducting our business and increase our efforts to have 100% membership of all Canadian oral and maxillofacial surgeons in the CAOMS.

Planning sessions included discussions on capitation, Canada Health Act, annual conventions, term of office and management companies for our conventions.

The president, Dr. Ron Warren, and executive of the CAOMS will host a cocktail party at the Ninth International Convention of Oral and Maxillofacial Surgeons for the presidents and dignitaries from around the world who will be attending.

Respectfully submitted,

Bernard M. Lyons, D.D.S.
Secretary

ADOPTION OF REPORT

The Report of the Canadian Association of Oral and Maxillofacial Surgeons received as information by the Board of Governors, with thanks.

CANADIAN ASSOCIATION OF ORTHODONTISTS

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

The Canadian Association of Orthodontists has had another successful year of operation. We now have an active membership list of approximately 80% of the 450 orthodontists practicing in Canada.

Because of the ever-increasing volume of correspondence and administrative responsibility, our Association has hired the professional administration firm of H.L. Taylor Ltd. of Toronto - a company handling administration for several other professional organizations. We are very gratified with the professional manner in which they are handling our affairs.

The CAO has initiated examinations of the following areas:

- 1) General insurance for office staff - to include extended health, dental, vision, life insurance and short and long term disability. It was the executive consensus that this would encourage the staff to consider our profession, rather than an interim employment - that would offer future protection. This block-type insurance is not presently available from CDSPI.
- 2) We initiated a public relations program to attempt to disseminate information to the public on the value of orthodontic treatment and in particular - orthodontic treatment by trained specialists.
- 3) We undertook a study by use of a professional research group to establish the public perception of orthodontists and in particular a comparison of treatment in a General practitioner's office vs. that in an Orthodontic specialist's office.
- 4) An Education Committee was set up to consider the proliferation of unqualified orthodontic lecturers who are now flooding the dental market-place with weekend courses giving certificates of qualification in specific areas of orthodontics. The CAO would like to voice its concern to the Board of Governors of the Canadian Dental Association and establish guidelines as to a possible accreditation of such courses.

The CAO is also concerned with the fragmentation of the specialists from the CDA by the lack of co-operation in allowing our meetings immediately prior to those of the national body. There is unquestionably some concern in smaller centers with accommodation problems. However, when you consider that our Association would require 100 rooms (at maximum) this should not be any problem in the larger centers. The CAO has cosponsored for many years the

CANADIAN ASSOCIATION OF ORTHODONTISTS

Grieve Memorial Lecture which was made available to both specialists and general practitioners. The status of this lecture seems questionable if we must hold our meetings with at least one day between the meetings. I believe the CDA is proliferating the division between the generalists and specialists even further by not encouraging their joint conferences.

Groups should be allowed to meet and overlap with the CDA annual sessions and be allowed at least first day access to commercial exhibits and meeting. The CDA could establish a dollar value to that day which would be added to our registration fee to the benefit not only of the commercial exhibitors but the interaction between dentists and specialists.

Because of our specific difficulties in dealing with the CDA Convention Committee we have chosen to hold our next two meetings separate from those of the CDA - the 1986 Meeting, one week prior to the CDA in Halifax and the 1987 Meeting in Toronto - CDA in Quebec City.

We would welcome encouragement by the CDA to again hold our meetings concurrent.

Respectfully submitted,

Morley I. Bernstein, D.D.S.
President - C.A.O.

ADOPTION OF REPORT

The Report of the Canadian Association of Orthodontists received as information by the Board of Governors, with thanks.

**ANNUAL
MEETING
BOARD OF GOVERNORS
CANADIAN DENTAL ASSOCIATION**

HALIFAX, NOVA SCOTIA

August 22-23

1986

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S. Deziel, Executive Assistant
J. Forsythe, Information Officer
C. Hackland, Editor

B. Henderson, Director of Accreditation
J. Neal, Director of Administration
L. Teteruck, Dir. of Educational Services
S. Vial, Accountant

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<u>NAME</u>	<u>AFFILIATION</u>
J.D. Aitken	Alberta Dental Association
E. Ambrose	University of Saskatchewan
S. Bangham	College of Dental Surgeons of British Columbia
B.D. Barrett	Dental Association of Prince Edward Island
J.F. Begin	Canadian Forces Dental Service
K. Bentley	McGill University
J. Blackmer	NB Department of Health and Comm. Services
B.L. Bowden	Newfoundland Dental Association
K. Butler	Canadian Dental Services Plans Inc.
M. Coady	Dental Association of Prince Edward Island
P. Cooney	Manitoba Ministry of Health
C. Covit	Ordre des Dentistes du Québec
M.J. Crompton	Royal College of Dentists of Canada
K. Croft	College of Dental Surgeons of British Columbia
T.M. Curry	Community Health Division - Alberta
S.B. Doshi	Public Health Branch - Newfoundland
J.C. Gillies	Ontario Dental Association
A. Gray	British Columbia Ministry of Health
T. Gushue	Newfoundland Dental Association
J. Hardie	Editorial Board
O.M. Heschuk	Manitoba Dental Association
R.N. Hicks	Chairman - Taxation Committee
G.P. Jocys	Nova Scotia Department of Health
I. Kleysteuber	Canadian Fund for Dental Education
G. Kravis	National Dental Examining Board of Canada
R. Laine	Medical Services Branch - Health & Welfare Canada
P.Y. Lamarche	Ordre des dentistes du Québec
C. Leblanc	New Brunswick Dental Society
M.J.R. Leitch	College of Dental Surgeons of British Columbia
B.P. Martinello	Alberta Dental Association
W.M. McKechnie	College of Dental Surgeons of Saskatchewan
R. McIntyre	Manitoba Dental Association
D. Montminy	Canadian Dental Services Plans Inc.
A. Newcombe	Canadian Dental Hygienists Association
D.V. Pamenter	Nova Scotia Dental Association
G.H. Peacock	College of Dental Surgeons of Saskatchewan
G.E. Pitkin	Royal College of Dental Surgeons of Ontario
K.F. Pownall	Royal College of Dental Surgeons of Ontario

OBSERVERS (Cont'd)

J.F. Reid	Canadian Fund for Dental Education
J.C. Roxborough	New Brunswick Dental Society
R. Smith	College of Dental Surgeons of British Columbia
G.W. Thompson	University of Alberta
J.G. Thompson	New Brunswick Dental Society
S. Vanry	College of Dental Surgeons of British Columbia
C. Wenn	Student - Dalhousie University
D.E. Williams	CDA Past-President
P. Zakarow	Student Governor-Elect

CANADIAN DENTAL ASSOCIATION

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Secretary to the Board of Governors

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J.N. Wright
J.W. Niedermayer

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J. Christie
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J.N. Wright

STUDENT REPRESENTATIVE

S. Sgro

HEALTH & WELFARE

W.R. Bedford

VETERANS AFFAIRS

J.C. Tsafaroff

Recording Secretary: Mrs. M. Lynch

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G.H. Peacock (Constitution & By-Laws)
R.Y. Barolet (Dental Materials)
A. Schwartz (Education & Accred.)
G.R. Thordarson (Ethics)
A. Toeman (Health Care)

J.H. Gryfe (Hosp. & Inst. Serv.)
Y. Kamachi (Information Serv.)
J.E. Durran (Insurance & Inv.)
P.R. Crawford (Nominations)
L. LeSaux (Student Affairs)

**PRESIDENT'S REMARKS
CDA ANNUAL BOARD OF GOVERNORS - HALIFAX
AUGUST 22-23, 1986**

I would like to welcome everyone to the Board of Governor's Meeting which will be my last as President. I'm sure there will be many sighs of relief at that particular aspect. I would just like to make a few brief comments about the year. I feel that the Canadian Dental Association is a viable association with very willing members. The people that I have dealt with this year have been willing to help, to pitch in, to be involved, and I think to help dentistry strike out in the right direction. I'm hopeful that over the next few years the CDA will continue to flourish and that we will all be better because of it. It has been a year of some frustrations, some successes and some failures, but it has always been interesting.

Although it has been a short year for me, having taken over in October, I'm not giving up the presidency until the end of the convention, Dr. Robertson, although the formality will be tonight. I have managed to instill sufficient fear in Dr. Robertson that he has actually registered as a dental technician for this particular convention. I feel that a year is sufficient under this kind of pressure and I think that it is with mixed emotions that I will be able to become a past president. I probably have not been the greatest President but I'm sure going to be the greatest Past-President this Association ever had. It's actually the position I was after to start with.

Again I would like to welcome you to the Board Meeting and I hope that our next couple of days will be fruitful. I would hope that we would be able to again stick to issues and leave personalities and personal feelings aside and try to get through the very large Board book. I look forward to seeing everyone tonight at John's installation. Have a good meeting!

EXECUTIVE

REPORT OF THE EXECUTIVE COUNCIL TO THE 1986 ANNUAL BOARD OF GOVERNORS MEETING

Members: Dr. Bradley W. Holmes, Kenora, Chairman
Dr. Edward F. Allison, Calgary
Dr. John Christie, Bedford
Dr. P. Ralph Crawford, Winnipeg
Dr. Gilles Dubé, Lachute
Dr. Ron J. Markey, Vancouver
Dr. Jack W. Niedermayer, Regina
Dr. John R. Robertson, Summerside
Brig.-Gen. James N. Wright, Ottawa

1. Council Meetings

Since the April Interim Board of Governors meeting, the Executive Council has met once - June 27-28, 1986.

ITEMS REQUIRING BOARD ACTION

2. Appointment of CDA Auditors

RESOLVED:

86.39 THAT the firm McCay-Duff & Company be appointed CDA auditors for the fiscal year 1986.

ADOPTED

3. CDA-RSP Financial Statements

APPENDIX A

Executive Council reviewed the audited financial statements for the CDA-RSP for the year ended May 31, 1986 prepared by Clarke Henning & Co.

RESOLVED:

86.40 THAT the audited financial statements for the CDA-RSP for the year ended May 31, 1986 be approved.

ADOPTED

4. CDSPI - Council on Insurance and Investment

To comply with Article XVI, Section 4(h) of the CDA Constitution & By-Laws,

RESOLVED:

86.41 THAT the Board of Directors of CDSPI be appointed the CDA Council on Insurance and Investment for the calendar year 1987.

ADOPTED

5. FDI - National Treasurer

The term of the National Treasurer to the FDI requires annual renewal. Dr. Robert N. Hicks will complete his second 1 year term in October, 1986.

RESOLVED:

86.42 THAT Dr. Robert N. Hicks be appointed as the CDA National Treasurer to FDI effective October, 1986.

ADOPTED

6. ACFD Membership - CDA Board of Governors

APPENDIX B

The Executive Council reviewed a 1985 submission from the Association of Canadian Faculties of Dentistry requesting one voting member on the CDA Board of Governors.

The Executive Council agrees that such membership would be of considerable benefit to the Canadian Dental Association.

RESOLVED:

86.43 THAT the ACFD be granted the right to appoint one non-voting member to the CDA Board of Governors.

DEFEATED

RESOLVED:

86.44 THAT the ACFD be granted the right to appoint one voting member to the CDA Board of Governors.

TABLED

7. CDA Honours and Awards

APPENDIX C

A report prepared on CDA Honours and Awards is appended. The report formalizes current procedures, and recommends the establishment of two additional awards - the Award of Merit and the CDA President's Award.

RESOLVED:

86.45 THAT the appended Report on Honours and Awards be accepted as guidelines for the Honours and Awards Sub-Committee; and,

THAT the terms of reference for the Sub-Committee contained therein be approved.

ADOPTED

A review of potential sources of funding for the President's Award is being carried out.

8. Membership Fee Increase

The Executive Council reviewed the necessity for a membership fee increase for the year 1988. Based on current financial projections,

RESOLVED:

86.46 THAT the membership fee for active members of the CDA be increased by 3.8% - \$10.00, for a total fee of \$270.00, and that this increase be effective January 1, 1988; and further that fee categories be increased proportionately to membership other than corporate members.

ADOPTED

The Executive Council will establish program and operations plans for 1988 at the November 1, 1986 Planning Session. Notice is hereby given that a further 1988 fee increase recommendation may be brought to the 1987 Interim Board if program and/or operations priorities so indicate.

9. Editorial Board

APPENDIX D

The Report of the Editorial Board is appended, and Executive comment on items requiring Board action is contained therein.

10. Third Party Dental Plans Committee

APPENDIX E

The Report of the Third Party Dental Plans Committee is appended, and Executive comment on items requiring Board action is contained therein.

11. 1987 Budget

APPENDIX F

The proposed 1987 Budget is appended, and explanatory notes are incorporated.

RESOLVED:

86.58 **THAT the 1987 Budget be approved.**

ADOPTED

Board approval of the budget was deferred until all reports with budgetary implications had been considered, and adjustment was made as required.

12. CDA Representatives to the CDSPI Board of Directors

The CDA currently appoints two representatives to the CDSPI Board of Directors, one from the province of Ontario, the other from the province of Quebec. As approved at the 1986 Interim Board of Governors Meeting, such appointments are to be mutually agreed to by the corporate members for Ontario and Quebec respectively, and the CDA.

The Annual Meeting of CDSPI, scheduled for August 23, 1986, will consider a motion to restructure the CDSPI Board.

RESOLVED:

86.59 **THAT the CDA appointments to the CDSPI Board of Directors for 1987 be deferred until after the 1986 Annual Meeting of CDSPI.**

ADOPTED

13. Restructuring CDSPI Board of Directors

At the May 1986 meeting of the CDSPI Board of Directors, approval was given to a motion on the restructuring of the CDSPI Board. This motion will be brought to the Annual meeting of CDSPI August 23, 1986. The Executive Council supports restructuring, as outlined in this motion.

RESOLVED:

- 86.60 **THAT the CDA voting representative to the 1986 Annual Meeting of CDSPI support the following motions:**

THAT the Management Committee members of Canadian Dental Service Plans Inc. shall be appointed on an equal basis as officials of the Board, and will not be voting directors of the Board, but be entitled to attend all meetings of the Board.

THAT the Board of Directors of Canadian Dental Service Plans Inc. be structured in the following manner:

- 1. The Provinces of British Columbia, Alberta and Quebec will each appoint one (1) voting director.**
- 2. The Province of Ontario will appoint two (2) voting directors.**
- 3. The Province of Manitoba and the Province of Saskatchewan will each appoint a representative to the Board of Canadian Dental Service Plans, Inc. One of these representatives shall be the voting director; the other shall be an observer.**
- 4. The Provinces of Prince Edward Island, Newfoundland, Nova Scotia and New Brunswick will each appoint a representative to the Board of Canadian Dental Service Plans Inc. One of these representatives shall be the voting director; the remaining three representatives shall be observers.**

-
5. The Canadian Dental Association will appoint two voting directors to the Board of Canadian Dental Service Plans Inc. One of these directors shall be appointed at large by the Canadian Dental Association. The other voting director shall be appointed from its Executive Council; this appointee will serve as Executive Liaison to the Council on Insurance and Investment.

ADOPTED

NOTE: CDA Governors from Quebec opposed the above motion.

14. 1987 Participation Agreement

APPENDIX G

The existing Participation Agreement (1986) provides for co-sponsors to discontinue participation in sponsored plans upon meeting certain notice requirements. The Executive Council is concerned that the existing termination provisions allow for actions which have a detrimental effect on the overall stability and performance of CDIP. In keeping with the terms of the 1986 Participation Agreement, proposed amendments to the Participation Agreement were circulated to Governors and Co-Sponsors on June 30, 1986.

RESOLVED:

- 86.61 THAT commencing with the Participation Agreements to be entered into as of January 1, 1987 between the Canadian Dental Association and the Co-Sponsors of the Canadian Dental Insurance Plans (the "Plans"), the Canadian Dental Association not enter into a Participation Agreement with any Co-Sponsor which does not agree to sponsor all of the Plans which are being sponsored by such Co-Sponsor during 1986 as listed in Schedule "A" of the 1986 Participation Agreement with such Co-Sponsor (the "Available Plans");

THAT the President of the Canadian Dental Association advise each of its Co-Sponsors, as soon as possible after the passing of this resolution, that it will not enter into a Participation Agreement as of January 1, 1987 with such Co-Sponsor unless such Co-Sponsor agrees to sponsor all of the "Available Plans";

THAT the President of the Canadian Dental Association cause the amendments to the forms of the Participation Agreements dated January 1, 1986 which are required in order to give effect to the foregoing provisions of this resolution to be circulated to the Board of Governors of the Canadian Dental Association and each Participating Organization (as defined in such Participation Agreements) on or before July 1, 1986 in accordance with the provision of section 5 of such Participation Agreements; and,

THAT the officers and directors of the Canadian Dental Association be, and are hereby authorized and directed, to take all other actions necessary or desirable in order to give effect to the foregoing provisions of this resolution.

ADOPTED

15. Certifying Board for General Dentistry

APPENDIX H

At the 1986 Interim Meeting, Governors deferred consideration of a CDA Position Statement on a Certifying Board for General Dentistry, in order to allow fuller discussion with representatives of the Certifying Board.

In May, 1986 representatives of the CDA met with Dr. Dan Loving, President of the Certifying Board and Dr. Robert Patrick, Past-President, AGD. Pertinent correspondence surrounding that meeting is appended.

A meeting was also held between CDA and the President of the AGD, Dr. Burton Schwartz, to discuss this issue.

The views of the NDEB were sought and are also provided for information.

The Report of the Council on Education and Accreditation contains a motion in support of the CDA Statement.

For the reasons delineated in the draft CDA position paper,

RESOLVED:

86.62 THAT the CDA Position on a Certifying Board for General Dentistry be approved.

ADOPTED

16. CDA Mission Statement**APPENDIX I**

As directed at the 1986 Interim Meeting of the Board, the CDA Mission Statement has been further reviewed and revised. Comment of corporate members was requested, received, and considered in the revision of the statement.

RESOLVED:

- 86.63 THAT the appended CDA Mission Statement be approved.**

ADOPTED**RESOLVED:**

- 86.64 THAT the Council on Constitution and By-Laws be directed to prepare the necessary by-law amendment.**

ADOPTED**17. Unproven Treatment Methods****APPENDIX J**

The appended statement on Unproven Treatment Methods was reviewed by the Council on Health Care, and the Council on Education and Accreditation, and was brought to the 1986 Interim Board by the Council on Ethics with recommendation for approval.

At the request of the Board, legal opinion on this statement was obtained and is appended.

RESOLVED:

- 86.65 THAT no further action be taken to develop a CDA Statement on Unproven Treatment Methods.**

ADOPTED**18. Ordre des Dentistes du Québec****APPENDIX K**

The Executive Council reviewed the correspondence received from the ODQ, pertaining to its present and future relationship with the CDA.

The request that the ODQ receive copies of all CDA accreditation reports related to Quebec institutions is under review.

Executive Council notes that the present by-laws do not allow for nominations from the ODQ. However, ODQ members may be nominated to Councils by Council Chairmen, Members of the Board of Governors, and Presidents and CEO's of Corporate Members and Specialty Sections. ODQ-sanctioned members currently hold positions on CDA Councils.

The ODQ nomination to the Council on Information Services does not meet current by-law requirements with regard to eligibility to nominate. However, the Executive Council recognizes the significant role of the ODQ in matters pertaining to Information Services, and believes that increased ODQ involvement in this area would be mutually beneficial to all concerned.

RESOLVED:

- 86.66 **THAT** the ODQ be permitted to name an observer to the Council on Information Services, for a one year trial period, provided that all expenses be borne by the ODQ.

MOTION WITHDRAWN

The request for a voting membership on the Board of Governors cannot be considered under current membership eligibility requirements of CDA by-laws. Executive Council recommends that the ODQ discuss this matter with the QDSA, and specifically in relation to the potential for broader Quebec participation on the Board of Governors, through increased membership.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

19. Five Year Financial Plan

APPENDIX L

A five-year financial plan is appended for information. The development of an associated five-year operational/program plan is underway, and will be reviewed at the November Executive Council Planning Session.

20. Management Committee

- Building Contingency Reserve Fund

On recommendation of the Management Committee, the Executive Council approved the transfer of \$20,000 from reserve funds to the Building Contingency Reserve Fund. This transfer is required to allow for anticipated expenses related to the parking lot expansion previously approved by the Board.

- Investment Alternatives

Management Committee is reviewing investment alternatives such as Treasury Bills or Term Deposits, for funds presently in current accounts.

- Foundations/Charities/Trust Funds

Following preliminary investigation by CDA Auditors, McCay Duff & Co., this item has been referred to Dr. Robert Hicks, Chairman of the Taxation Committee. Dr. Hicks will report to the Board on this item after further review.

- CDA Mortgage

In keeping with the Board's direction, Management Committee reviewed the status of the mortgage on the CDA building. No adjustment to present terms is indicated.

- Corporate and Licensing Body Fee Increases

All corporate and licensing bodies have been formally notified of the 1987 fee increases. Further discussion is required on the development of a mechanism and process for future increases. A committee will be established with representatives of corporate bodies and licensing authorities and a further report, if required, brought to a future meeting of the Board.

- Property Management

APPENDIX M

A report on Leasing Status as of July, 1986 is appended.

The leasing of space and provision of management services to Specialty Sections and Affiliated Societies on a cost recovery basis is being investigated.

- Eleventh Congress-International Association of Dentistry for Children

On recommendation of the Management Committee, the Executive Council approved the sum of \$1,000 in support of the Eleventh Congress-International Association of Dentistry for Children. The Congress falls within the terms of reference for CDA grants to international dental meetings, and suitable recognition of CDA support will be displayed to participants at the meeting.

- Haiti Budget

On recommendation of the Management Committee, Executive Council approved the sum of up to \$8,000 to cover equipment and administrative expenses related to the Haiti Project. The Canadian International Development Agency has granted \$25,000 towards this project, and the University of Montreal will provide support in kind equivalent to \$16,500.

21. FDI National Treasurer's Report

APPENDIX N

At the 1986 World Dental Congress in Manila, formal approval will be recommended of the proposal that Vancouver, Canada host the FDI Congress in 1994.

A full report from the National Treasurer is appended.

22. Consumer Products Recognition

APPENDIX O

The Report of the Committee on Consumer Products Recognition is appended for information.

23. Membership Committee

The Report of the Membership Committee is appended.

APPENDIX P

Executive Council has approved applications for Supporting Membership and Life Membership as indicated.

24. Professional Resource Utilization Committee

APPENDIX Q

The report of the Professional Resource Utilization Committee is appended for information. An update related to activities on the demand study will be provided by the Committee Chairman at the Annual Meeting.

25. Government Relations Committee

APPENDIX R

On May 28, 1986, Management Committee met with the Honourable Jake Epp, Minister of Health and Welfare. Mr. Neilson, Dr. W.R. Bedford, Mr. David Nicholson, ADM - Medical Services Branch, and Dr. Peter Glynn, ADM - Health Services & Promotion Branch, were also present. A broad range of issues was discussed, including the Canada Health Act, the National School of Dental Therapy, the Medical Services Review Team, and the CDA Brief to the Legislative Committee on Bill C-96.

During the week of the June Executive Council Meeting, the Chairman, Dr. Markey met with Mr. David Nicholson, ADM, Medical Services Branch and Denise Michaud, Special Assistant to Jake Epp, Minister of Health and Welfare Canada. Discussions related to the ongoing and future relationship between CDA and Health and Welfare Canada.

A summary of on-going government relations activities is appended.

Mr. David Nicholson, ADM - Medical Services Branch, will address Governors and Presidents and Chief Executive Officers of Corporate members on August 21, 1986, at a dinner on the eve of the 1986 Annual Meeting.

26. Taxation Committee

APPENDIX S

The Report of the Taxation Committee is appended.

The Executive Council extends its thanks and appreciation to the Chairman, Dr. Hicks, for his continued efforts on behalf of the CDA.

27. Convention Committee

APPENDIX T

The Report on CDA Conventions 1986-1988 is appended. The Executive Council has appointed Dr. Michel Jahjah as the Chairman of the 1987 Convention, being held in conjunction with Les Journées Dentaires of l'Ordre des Dentistes du Québec, in Montréal, May 24-28, 1987. Planning for the 1988 Convention is proceeding, following the terms of the existing CDA Convention Protocol.

28. Ad Hoc Committee on Conventions

Discussion is underway with potential nominees of the Ad Hoc Committee on Conventions. The Executive Council will consider future CDA convention locations 1989-1993 at the November 1986 Planning Session.

29. CDA Committee on Dental Specialties

The Roles and Responsibilities Committee has considered a proposal by representatives to the 1986 Annual Meeting of Specialty Sections, to establish a Council on Dental Specialties.

The Executive Council has approved an Ad Hoc Committee to further investigate all benefits and ramifications of the establishment of a Committee on Dental Specialties. The Committee, if approved, would function as a standing committee of Executive Council, to address specific concerns of specialty sections similar to the mandate of the Committee on Salaried Dentists.

30. Third World Assistance

APPENDIX U

Recent activities in this area have seen the approval, by the Canadian International Development Agency, of the continuation of two CDA projects - Haiti and St. Kitts/Nevis. Pertinent correspondence is appended.

It is anticipated that CDA's involvement in Third World Assistance will expand, based in the principle of offering administrative and coordinating support.

Dr. George Beagrie is currently pursuing a program in Thailand, in which CDA will be involved in the above context.

31. Independent Review of Dental Services

On June 26, Management Committee and Mr. Neilson met with members of the Medical Services Branch - Dental Services Review Team, comprised of Dr. Raymond Laine, Mr. William Ross and Mr. Henry Wilson.

CDA representatives raised the issues of the National School of Dental Therapy and the CDA desire for a change in philosophy towards a preventative orientation to the School's program.

Medical Services Branch anticipates a report from the Review Team in late August or early September. The Executive Council will consider an independent critique of this report once it becomes available.

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32. Bill C-96 - An Act to Amend the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977

APPENDIX V

On June 3, 1986, Dr. John Robertson, President-Elect, Dr. Arthur Schwartz, Chairman, Council on Education and Accreditation, Mr. Jardine Neilson, Executive Director, and Mr. Brian Henderson, Director of Accreditation presented the CDA brief on Bill C-96.

The brief is appended for information.

33. National Aids Centre

APPENDIX W

Following correspondence between CDA and Health and Welfare Canada on the establishment of a National Aids Centre, Mr. Neilson met with Mr. Greg Smith, Coordinator of the Centre, and Dr. W.R. Bedford, to discuss CDA's role.

CDA has agreed to assist in the gathering of information pertaining to dentistry and AIDS. The appointment of Dr. Hardie, as CDA representative to a role with the NAC, is under consideration.

34. MD Growth Investment - CMA

APPENDIX X

A proposal received from the Canadian Medical Association on participation in CMA investment programs is appended. The Executive Council has instructed the Council on Insurance and Investment to further investigate the CMA proposal and report on its recommendations. The Executive Council will consider the option of such an investment program being available to CDA members.

35. Council on Ethics - Review of Mandate

Dr. Roy Thordarson, Council Chairman, met with Executive Council to review the mandate and direction of his Council, following actions taken at the 1986 Interim Board.

It was agreed that the Council on Ethics should pursue preparation of CDA guidelines on various matters involving ethics. These guidelines will be brought to the Board for information, as statements of the Council on Ethics, for utilization by the CDA and other provincial associations as they deem appropriate.

Further information is provided in the Report of the Council on Ethics.

36. ACFD

The President of ACFD, Dr. Marcia Boyd, delivered a presentation to the Executive Council on the history and role of the ACFD. Dr. Boyd's presentation highlighted several important issues facing dentistry, and stressed that the close relationship existing between the CDA and ACFD will aid in the examination and development of solutions as these issues are considered. Dr. Boyd has been invited to make a similar presentation to the Board.

37. Applications for Temporary Registration - Government of the Northwest Territories

As reported at the Interim Board, a meeting was held with officials of the CDA, the NDEB and the Government of the NWT, to review a request for CDA assistance concerning applications for temporary registration. As a result of this meeting, the Government of the NWT will reconsider its approach to overcoming the problems of temporary registration.

38. CDA Awards - Honorary Membership - Distinguished Service

The Executive Council is not recommending the award of Honorary Membership or the Distinguished Service Award for 1986.

The newly-formed Sub-committee on Honours and Awards will solicit and consider names for awards in 1987, following the procedures outlined in the Report on Honours and Awards.

39. Brig-Gen. James N. Wright

The Executive Council expresses sincere appreciation to Brig-Gen. James N. Wright for service to CDA, through his role on Executive Council and as Chairman of the Committee on Salaried Dentists. General Wright's contribution in Executive liaison positions to the Councils on Health Care, and Insurance and Investment, have been outstanding and are duly recognized.

40. President's Activities

APPENDIX Y

The activity schedule of the President during his term in office is appended for information.

41. Council Reports

Executive Council has reviewed Council reports as appended, and other matters requiring Board action follow therein.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read 'B W Holmes', written in a cursive style.

Bradley W. Holmes, D.D.S.
Chairman - Executive Council

ADOPTION OF REPORT

The Board of Governors accepts the report of the Executive Council with appreciation.

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

FINANCIAL STATEMENTS

Year ended May 31, 1986

Auditors' Report	Page 1
Statement of Financial Position	2
Statement of Income	3
Statement of Changes in Net Assets	4
Investment Portfolios	5 to 10
Notes to Financial Statements	11 to 12

Clarke
Henning
& Co.

44 Victoria Street
Toronto, Ontario
Canada M5C 1Y3
Tel. (416) 364-4421

AUDITORS' REPORT

TO THE BOARD OF GOVERNORS OF THE CANADIAN DENTAL ASSOCIATION
TRUSTEES FOR THE PARTICIPANTS IN THE CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

We have examined the statement of financial position and investment portfolios of the Canadian Dental Association Retirement Savings Plan as at May 31, 1986 and the statements of income and changes in net assets for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position and investment portfolios of the Plan as at May 31, 1986 and the results of its operations and the changes in its net assets for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Clarke Henning & Co.
CHARTERED ACCOUNTANTS

Toronto, Ontario
June 11, 1986

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN
STATEMENT OF FINANCIAL POSITION

As at May 31, 1986

	1986	1985
ASSETS		
Fixed income fund		
Investments, at market value		
Bond fund units	\$ -	\$ 8,275,014
Mortgage fund units	2,967,526	2,600,491
Bonds	12,542,471	375,025
Cash and short-term deposits	541,045	943,333
Accrued income	396,690	12,117
	<u>16,447,732</u>	<u>12,205,980</u>
Common stock (equity) fund		
Investments, at market value		
Common stocks	22,167,273	18,658,002
Cash and short-term deposits	5,028,843	657,140
Accrued income	113,629	67,253
	<u>27,309,745</u>	<u>19,382,395</u>
Money market fund		
Investments, at market value		
Money market fund units	10,873,205	11,141,044
Cash and short-term deposits	(83,919)	(60,919)
	<u>10,789,286</u>	<u>11,080,125</u>
Balanced fund		
Investments, at market value		
Diversified fund units	4,847,609	2,164,739
Cash and short-term deposits	12,415	95,526
Accrued income	-	433
	<u>4,860,024</u>	<u>2,260,698</u>
Guaranteed fund		
Investments certificates of The Imperial Life Assurance Company of Canada	1,503,631	792,530
Accrued interest	152,378	17,599
	<u>1,656,009</u>	<u>810,129</u>
Total assets of the plan	<u><u>\$61,062,796</u></u>	<u><u>\$45,739,327</u></u>

Approved on behalf of Canadian Dental Association:

_____, Governor _____, Governor

	1986	1985
PARTICIPANTS' INTEREST		
Fixed income fund	\$16,447,732	\$12,205,980
Common stock (equity) fund	27,309,745	19,382,395
Money market fund	10,789,286	11,080,125
Balanced fund	4,860,024	2,260,698
Guaranteed fund	1,656,009	810,129
Total participants' interest	<u>\$61,062,796</u>	<u>\$45,739,327</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

STATEMENT OF INCOME

Year ended May 31, 1986

	1986	1985
Fixed income fund		
Income		
Interest - Bonds	\$ 146,633	\$ 16,110
- Cash and short-term deposits	240,731	179,754
Profit on sale of investments	<u>3,067,147</u>	<u>195,864</u>
	3,454,511	
Expenses		
Administration fees	72,431	53,987
Other	<u>1,220</u>	<u>2,157</u>
	73,651	56,144
Net Income	<u><u>3,380,860</u></u>	<u><u>139,720</u></u>
Common stock (equity) fund		
Income		
Dividends	559,045	529,381
Interest - Cash and short-term deposits	229,860	194,252
Profit on sale of investments	<u>2,387,393</u>	<u>812,792</u>
	3,176,298	1,536,425
Expenses		
Administration fees	111,789	87,587
Other	<u>1,915</u>	<u>3,531</u>
	113,704	91,118
Net Income	<u><u>3,062,594</u></u>	<u><u>1,445,307</u></u>
Money market fund		
Income		
Interest - Bonds		30,448
- Cash and short-term deposits	12,855	35,622
Profit on sale of investments	<u>481,787</u>	<u>32,783</u>
	494,642	98,853
Expenses		
Administration fees	58,122	56,212
Other	<u>1,040</u>	<u>2,252</u>
	59,162	58,464
Net Income	<u><u>435,480</u></u>	<u><u>40,389</u></u>
Balanced fund		
Income		
Interest - Cash and short-term deposits	\$ 9,681	\$ 7,598
Profit on sale of investments	<u>3,570</u>	<u>6,651</u>
	13,251	14,249
Expenses		
Administration fees	15,743	10,148
Other	<u>247</u>	<u>406</u>
	15,990	10,554
Net Income (loss)	<u><u>(2,739)</u></u>	<u><u>3,695</u></u>
Guaranteed fund		
Interest income	\$ 134,779	\$ 17,599

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

STATEMENT OF CHANGES IN NET ASSETS

Year ended May 31, 1986

	1986	1985
Fixed income fund		
Net deposits	\$ 2,483,276	\$ 261,802
Net income	3,380,860	139,720
Change in market value of investments	(1,622,384)	1,842,744
Increase in net assets	4,241,752	2,244,266
Net assets at beginning of period, at market value	12,205,980	9,961,714
Net assets at end of period, at market value	<u>16,447,732</u>	<u>12,205,980</u>
Unit value	<u>51.83559</u>	<u>45.71355</u>
Common stock (equity) fund		
Net deposits (redemptions)	2,727,938	(1,881,169)
Net income	3,062,594	1,445,307
Change in market value of investments	2,136,818	3,274,239
Increase in net assets	7,927,350	2,838,377
Net assets at beginning of period, at market value	19,382,395	16,544,018
Net assets at end of period, at market value	<u>27,309,745</u>	<u>19,382,395</u>
Unit value	<u>120.17464</u>	<u>95.29689</u>
Money market fund		
Net redemptions	(1,332,083)	(516,567)
Net income	435,480	40,389
Change in market value of investments	605,764	1,141,982
Increase in net assets	(290,839)	665,804
Net assets at beginning of period, at market value	11,080,125	10,414,321
Net assets at end of period, at market value	<u>10,789,286</u>	<u>11,080,125</u>
Unit value	<u>34.85591</u>	<u>31.76951</u>
Balanced fund		
Net deposits	2,042,665	30,955
Net income (deficit)	(2,739)	3,695
Change in market value of investments	559,400	440,225
Increase in net assets	2,599,326	474,875
Net assets at beginning of period, at market value	2,260,698	1,785,823
Net assets at end of period, at market value	<u>4,860,024</u>	<u>2,260,698</u>
Unit value	<u>22.14624</u>	<u>18.65581</u>
Guaranteed fund		
Net deposits	711,101	792,530
Net income	134,779	17,599
Increase in net assets	845,880	810,129
Net assets at beginning of period	810,129	-
Net assets at end of period	<u>\$ 1,656,009</u>	<u>\$ 810,129</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

FIXED INCOME FUND

Units	No. of Units Par Value	Average Cost	Market Value
The Imperial Life Assurance Company of Canada Pooled Mortgage Fund Units	51,964	\$ 2,052,747	\$ 2,967,526
Bonds			
Government of Canada			
June 6, 1987 - 10%	550,000	553,300	553,300
September 1, 1987 - 14.25%	800,000	974,000	956,000
February 1, 1990 - 13.25%	300,000	336,000	331,200
October 15, 1992 - 13.5%	300,000	357,000	349,950
December 15, 1992 - 11.75%	350,000	392,875	384,650
December 15, 1993 - 11.5%	400,000	446,600	438,200
June 15, 1994 - 9.5%	775,000	794,375	777,325
October 1, 2001 - 9.5%	500,000	520,313	510,500
February 1, 2003 - 11.75%	550,000	647,625	633,050
March 1, 2005 - 12%	350,000	419,475	408,625
September 1, 2005 - 12.25%	850,000	1,036,150	1,009,375
June 1, 2008 - 10%	500,000	529,750	514,500
November 1, 1987 - coupon	58,500	50,386	51,334
May 1, 1988 - coupon	58,500	48,116	48,994
November 1, 1988 - coupon	58,500	45,852	46,654
May 1, 1989 - coupon	58,500	43,729	44,533
November 1, 1989 - coupon	58,500	41,681	42,485
May 1, 1990 - coupon	58,500	39,780	40,511
November 1, 1990 - coupon	58,500	37,879	38,464
May 1, 1991 - coupon	58,500	36,054	36,709
		<u>7,350,940</u>	<u>7,216,359</u>
Provincial Bonds			
Newfoundland Municipal Finance 10.375% due March 3, 2000	650,000	646,750	632,775
Ontario 7.75% due December 1, 1997	100,000	87,500	87,300
Ontario Hydro 9.5% due March 19, 1991	1,000,000	1,002,500	1,007,500
Ontario Hydro 9.25% due January 6, 2004	1,400,000	1,345,750	1,319,500
		<u>3,082,500</u>	<u>3,047,075</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

FIXED INCOME FUND - Continued

Bonds	Par Value	Average Cost	Market Value
Corporate Bonds			
Bank Montreal Leasing 11.75% due December 15, 1988	400,000	\$ 414,000	\$ 413,200
Bank Montreal Mortgage Corp. 10.84% due September 5, 1990	250,000	256,250	254,062
CIBC Mortgage Corp. 11.25% due January 11, 1988	300,000	304,800	305,850
CIBC Mortgage Corp. 10.375% due June 18, 1990	250,000	252,200	250,625
Continental Bank 11.00% due June 21, 1990	500,000	500,000	500,000
Royal Bank 11.67% due January 10, 1989	250,000	258,750	258,250
Roymar Mortgage 12.25% due August 26, 1988	200,000	208,160	207,750
Traders Group 8.75% due May 1, 1993	100,000	88,750	89,300
		<u>2,282,910</u>	<u>2,279,037</u>
Total bonds		<u>12,716,350</u>	<u>12,542,471</u>

COMMON STOCK (EQUITY) FUND

Canadian Equities			
Communications and Media			
Astral Bellevue Pathe Inc. Class B	2,000	10,160	27,750
Astral Bellevue Pathe Inc. Class A	40,000	242,000	550,000
Shaw Cablesystems Ltd. Class B	33,000	561,000	552,750
Thompson Newspapers Class A	26,100	325,758	822,150
		<u>1,138,918</u>	<u>1,952,650</u>
Consumer Products			
Imasco Ltd.	17,000	516,085	592,875
Magna International Inc. Class A	19,000	255,102	627,000
Nabisco Brands Ltd.	11,100	259,908	477,300
		<u>1,031,095</u>	<u>1,697,175</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

COMMON STOCK (EQUITY) FUND - Continued

Canadian Equities	No. of Shares	Average Cost	Market Value
Financial Services			
Bank of Nova Scotia	21,800	\$ 312,729	\$ 324,275
Canadian Imperial Bank of Commerce	39,500	607,043	730,750
Canadian Imperial Bank of Commerce warrants	8,300	18,592	59,138
National Bank Canada	9,700	217,620	276,450
Power Financial Corporation	24,400	333,975	646,600
Toronto-Dominion Bank	31,403	334,988	737,970
Traders Group Ltd. Class A	19,400	447,558	989,400
		<u>2,272,505</u>	<u>3,764,583</u>
Golds			
Echo Bay Mines	9,000	115,058	173,250
Placer Developments Limited	14,400	374,400	322,200
		<u>489,458</u>	<u>495,450</u>
Industrial Products			
GEAC Computer Con 9.00 Oct 1/95	300,000	300,000	234,000
Ipsco Inc.	7,300	99,758	74,825
Moore Corporation Ltd.	49,047	456,664	1,784,085
Northern Telecom Ltd.	11,300	551,890	466,125
		<u>1,408,312</u>	<u>2,559,035</u>
Merchandising			
Computer Innovation Distribution Inc.	94,400	279,424	344,560
Dylex Ltd. Part C1 A Pfd.	43,200	622,458	739,800
Weston George Ltd.	40,000	551,000	1,320,000
		<u>1,452,882</u>	<u>2,404,360</u>
Metals and Minerals			
Brunswick Mining & Smelting	27,000	273,046	351,000
Falconbridge Mines Ltd.	16,000	275,440	346,000
Teck Corporation Class B	9,100	217,011	195,650
Teck Corporation 7.25% Ser F Cum. Red. Cv. Pfd.	8,200	205,000	278,800
		<u>970,497</u>	<u>1,171,450</u>
Oil and Gass			
Alberta Energy Co.	24,200	481,361	302,500
Norcen Energy Resources	12,000	138,840	165,000
Shell Canada Ltd. Class A	16,100	445,902	380,362
		<u>1,066,103</u>	<u>847,862</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

COMMON STOCK (EQUITY) FUND - Continued

Canadian Equities	No. of Shares	Average Cost	Market Value
Paper and Forest Products			
British Columbia Forest	18,000	\$ 236,250	\$ 238,500
Consolidated Bathurst S-A	11,900	200,915	293,038
		<u>437,165</u>	<u>531,538</u>
Pipelines			
Interprovincial Pipelines	15,000	414,000	658,125
Transcanada Pipelines Ltd.	21,000	249,630	383,250
		<u>663,630</u>	<u>1,041,375</u>
Real Estate and Construction			
Bramalea Ltd.	13,800	241,134	286,350
Campeau Corporation Common New	12,000	216,000	336,000
Trizec Corporation Class A	6,400	135,350	251,200
Trizec Corporation Class B	12,300	272,405	479,700
		<u>864,889</u>	<u>1,353,250</u>
Transportation			
Laidlaw Transportation Ltd. Class A	43,000	100,897	892,250
Utilities			
Bell Canada Enterprises Ltd.	20,100	608,622	788,925
Transalta Utilities Class A	9,652	145,231	272,669
		<u>753,853</u>	<u>1,061,594</u>
Total Canadian Equities (89.20%)		<u>12,650,204</u>	<u>19,772,572</u>
United States Equities			
Basic Industries			
Dow Chemical Company	1,600	69,566	124,915
Ethyl Corp.	2,000	104,568	109,162
Henley Group	2,000	58,395	59,072
		<u>232,529</u>	<u>293,149</u>
Capital Goods			
Research - Cottrell	2,000	67,139	86,708
Westinghouse Electric Corporation	5,000	143,486	370,495
		<u>210,625</u>	<u>457,203</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

COMMON STOCK (EQUITY) FUND - Continued

United States Equities	No. of Shares	Average Cost	Market Value
Capital Goods - Technology			
Andrew Corp.	4,000	\$ 125,279	\$ 114,689
Boeing Company	5,400	211,820	435,578
		<u>337,099</u>	<u>550,267</u>
Consumer Cyclicals			
General Motors Corporation	600	49,768	66,016
Trans World Corporation	2,259	79,583	148,661
		<u>129,351</u>	<u>214,677</u>
Consumer Growth			
Johnson & Johnson	2,200	121,058	207,857
Merck & Company Inc.	800	47,892	106,675
Pepsico Inc.	2,100	30,363	98,298
		<u>199,313</u>	<u>412,830</u>
Credit Cyclicals			
Owens Corning Fiberglas Corporation	1,400	75,462	99,870
Defensive Consumer Staples			
Anheuser Busch Cos. Inc.	1,000	70,037	70,644
Clorox Company	2,200	76,668	166,438
		<u>146,705</u>	<u>237,082</u>
Financial			
American General Corporation Pfd. D	1,000	42,805	55,617
Utilities			
Centerior Energy Ltd.	2,220	80,202	74,006
Total United States Equities (10.80%)		<u>1,454,091</u>	<u>2,394,701</u>
Total Common Stocks (100.00%)		<u>14,104,295</u>	<u>22,167,273</u>

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

INVESTMENT PORTFOLIOS

As at May 31, 1986

MONEY MARKET FUND

Units	No. of Units	Average Cost	Market Value
The Imperial Life Assurance Company of Canada Pooled Money Market Units	652,709	<u>\$ 8,347,618</u>	<u>\$10,873,205</u>

BALANCED FUND

The Imperial Life Assurance Company of Canada Pooled Diversified Fund Units	116,602	<u>\$ 3,810,369</u>	<u>\$ 4,847,609</u>
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CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN
NOTES TO FINANCIAL STATEMENTS

Year ended May 31, 1986

1. Summary of significant accounting policies

The financial statements have been prepared in accordance with accounting principles generally acceptable for pooled trust funds. A description of accounting policies of particular significance is as follows:

a) Investments

Investments are stated at market value, determined as follows:

- (i) Stocks listed on a recognized stock exchange valued at the closing sale prices.
- (ii) Bonds valued at the average of bid and ask prices at May 31, 1986.
- (iii) Units of The Imperial Life Assurance Company of Canada are valued on the last business day of each week by dividing the total number of units of the Fund then outstanding into the net assets of the Fund, being the fair market value in Canadian funds of assets less liabilities as at the same date.

b) Valuation of units

Units are valued for the purposes of issue or redemption as at the close of business on the last business day of each week by dividing the total number of units of the Fund then outstanding into the net assets of the Fund, being the fair market value in Canadian funds of assets less liabilities as at the same date.

c) Income

Dividends are recognized as income on the ex-dividend date. Interest income is accrued at the stated rate of the debt security.

d) Contributions, transfers, terminations

All contributions, transfers and terminations made by the participants of the plan have been accounted for on an accrual basis.

CANADIAN DENTAL ASSOCIATION
RETIREMENT SAVINGS PLAN

NOTES TO FINANCIAL STATEMENTS

Year ended May 31, 1986

1. Summary of significant accounting policies - continued

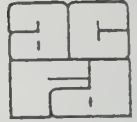
e) Foreign currency translation

Accounts in foreign currencies have been translated into Canadian dollars as follows:

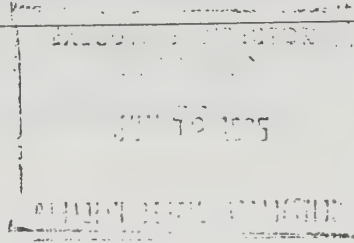
- (i) current assets and current liabilities at the exchange rate prevailing at the Balance Sheet date;
- (ii) purchases and sales of investments and revenue and expenses at the rate of exchange prevailing on the respective dates of such transactions.

Gains or losses resulting from the translation of foreign currencies are included in income.

The Association of Canadian Faculties of Dentistry/
L'Association des facultés dentaires du Canada



Office of the President



Faculty of Dentistry
University of Manitoba
780 Bannalyne Avenue
WINNIPEG, Manitoba
R3E 0W3

Phone (204) 786-3631

June 5, 1985

Dr. P.R. Crawford, President
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

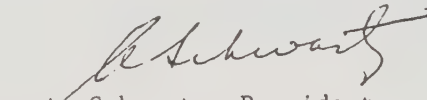
Dear Dr. Crawford:

You have been aware, for the past year or more, of an interest on the part of ACFD/AFDC in obtaining voting membership on the CDA Board of Governors. There is a strong feeling within the Executive Council of our Association, and the membership at large, that the CDA and ACFD/AFDC would benefit from such a change. The size of our membership and the role which we play in the dental health profession in Canada should warrant favourable consideration for the attached proposal.

We would welcome the opportunity to discuss this matter further, at any level of the CDA organization which you might deem appropriate.

It is our sincere hope that favourable consideration will be given to this proposal.

Respectfully submitted


A. Schwartz, President

AS/ln
Att.

A POSITION PAPER

Respecting the Establishment of

A Voting Membership on

the

BOARD OF GOVERNORS

of the

CANADIAN DENTAL ASSOCIATION

Presented by:

THE ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY

L'ASSOCIATION DES FACULTES DENTAIRE DU CANADA

A) Introduction

a) HISTORY

The Association of Canadian Faculties of Dentistry/L'Association des Facultés dentaires du Canada (hereinafter called ACFD/AFDC) was formed in March, 1967, in response to a perceived need for an organization which would work in the common interests of, and provide a collective voice for, Canadian dental educators and researchers.

The general philosophy of the new organization which was enunciated at that time was: "It is most important that this organization work to establish national standards in research as well as in educational policies."

The Constitution and Bylaws which were approved in 1967 have been

subject to careful and continuing review and amendment to keep in tune with the growth of the Association and the changing scope and circumstances of dental education and research.

b) Objectives of the Association of Canadian Faculties of Dentistry

- A) promote the advancement of teaching and research in dentistry;
- B) facilitate the exchange of information and opinions among those engaged in dental education and research;
- C) promote the provision of dental personnel to meet Canada's present and future health care requirements;
- D) promote the development of post-graduate and graduate dental education;
- E) promote opportunities for the continuing education of dental personnel;
- F) promote public understanding and appreciation of the quality and value of education and research;
- G) engage in any activity consistent with the ethics of the profession and with the Constitution and Bylaws to advance the interest of dental education and research.

c) Membership

Institutional Members

The ten Canadian Dental Faculties are the Institutional members of the Association

Affiliate Members

Agencies, institutions and organizations which conduct dental education programs, except those which are eligible for institutional or provisional membership, may apply for affiliate membership provided their programs are accredited by the Council on Education of the Canadian Dental Association as accreditation eligible, preliminary approval, provisional approval, conditional approval or full approval.

(a) Colleges and universities and independent post-graduate training research centres;

(b) The Canadian Forces Dental Service School;

(c) Education or Health Care Institutions with programs in any of the following categories:

- (i) hospital and dental internships and residencies,
- (ii) dental hygiene
- (iii) dental assisting
- (iv) dental laboratory technology

d) Organization

i) House of Delegates

The House of Delegates is the supreme authoritative body of the Association. It is composed of the dean and two elected delegates from each of the ten dental faculties, one representative from Canadian Forces Dental Service School, one representative of the Sections of the Association and the members of the Executive Council.

ii) Executive Council

The Executive Council is composed of the President,

immediate Past President/or the President-elect, three elected members-at-large, the Chairman of the Committee on Research, the Chairman of the Committee on Education, and two other members ex-officio - namely; the Executive Director, and a representative from the Council on Education of the Canadian Dental Association

iii) Standing Committees

Education Committee

The Chairman and five other members elected for three-year terms by the House of Delegates.

Research Committee

The Chairman and five other members are elected for three year terms by the House of Delegates.

Constitution Committee

The Chairman Chairman and one member are elected by the House of Delegates for three-year terms.

e) Manpower

ACFD/AFDC is the Association representing the academic staff, which works to the benefit of the student body in the ten Canadian dental schools. The number of persons concerned is considerable. The following figures represent the total academic staff and students involved in the 10 dental schools in Canada:

Full-time academic staff	-	485
Part-time academic staff	-	1200
Undergraduate dental students	-	2000

B) Discussion

a) Goals and History

The general philosophy and objectives of both the Canadian Dental Association and the Association of Canadian Faculties of Dentistry are the cultivation and advancement of the art and science of dentistry and the maintenance of professional ethics. Further, a study of the specific objectives and purposes of each organization also indicates a notable similarity between these goals. A comparative summary appears in the following table:

ASSOCIATION OBJECTIVES

(Excerpted from the Constitution and Bylaws of ACFD and CDA)

ACFD	CDA
i) To promote the advancement of teaching and research in dentistry	i) To elevate and sustain the professional character and <u>education</u> of dentists ii) To conduct, direct, encourage and support or provide for exhaustive dental and oral <u>research</u>
i) To facilitate the exchange of information and opinions among those engaged in dental <u>education</u> and <u>research</u>	i) To conduct, direct, encourage and support or provide for exhaustive dental and oral <u>research</u> ii) To disseminate <u>knowledge</u> of dentistry and dental <u>discoveries</u>
i) To promote the provision of dental personnel to meet Canada's present and future health care requirements	i) To cultivate and promote the art and science of dentistry and all its collateral branches, and to maintain the honour and interests of the dental profession
i) To promote the development of post-graduate and graduate dental education ii) To promote opportunities for the continuing education of dentists	i) To elevate and sustain the professional character and education of dentists
i) To promote public understanding and appreciation of the quality and value of education and research	i) To disseminate knowledge of dentistry and dental discoveries ii) To enlighten and direct public opinions in relation to advanced scientific dental service
i) To engage in any activity consistent with the ethics of the profession to advance the interest of dental education and research	i) To elevate and sustain the professional character and education of dentists ii) To conduct, direct, encourage and support or provide for exhaustive dental and oral research

b) Dental Research

For a number of years CDA actively cultivated and promoted the advancement of dental research in Canada, largely through its Council on Research. Since practically all dental research has been, and is being, done in the dental schools, this Council was composed of researchers who were academic staff of the dental faculties. When the CDA dissolved the Council on Research some years ago, the Research Committee of ACFD became the representative body for dental researchers in Canada. Since that time the Canadian Association for Dental Research was formed and the ACFD Research Committee is currently composed of three members elected from each of ACFD and CADR.

ACFD is, therefore, a major voice for Canadian dental research, a matter of significance to both CDA and ACFD/AFDC

c) Dental Education

Dental Education is a principal focus for the ACFD. The teaching and training of undergraduate dental and dental hygiene students is a major function of the Faculties of Dentistry. In addition, many schools have graduate and post-graduate programs in dental specialties. Every dental school is involved with programs in continuing education for the profession. Indeed, the faculty members provide a valuable resource for continuing education courses. ACFD, with advice of its Education Committee, continually strives to cultivate and promote improved and effective teaching at the undergraduate and graduate levels, and its faculty members work very closely with the CDA and its Committee on Continuing Education to provide programs and courses for dental professionals.

C) Conclusions

The goals of ACFD are similar to those of CDA. A major objective, which is common to both associations, is to elevate and sustain the

professional character and education of dental professionals and to cultivate and promote the art and science of dentistry. ACFD, through its member institutions, strives to achieve these objectives at the education and research levels, while CDA functions well at the level of the practitioner of dentistry.

The numbers of people represented, directly and indirectly, by ACFD is significant. A very high percentage of these individuals are Active Members and Student Members of CDA. In view of the large number of members represented by ACFD, it would appear to be reasonable that ACFD should seek voting membership on the Board of Governors of CDA.

Dental research in Canada is performed primarily by academic staff of ACFD member institutions. Their work benefits the profession and the public, which are the trust of CDA. Also benefited are the staff and students who are in the direct area of activity of ACFD. It would appear that a closer working arrangement for CDA and ACFD would be both desirable and advisable.

The entire area of dental education and research is one in which the interests of CDA and ACFD come together. It would seem to be in the best interests of both organizations, if ACFD had the opportunity to serve as a member of the Board of Governors.

D) Resolution

WHEREAS, the goals and objectives of the Canadian Dental Association (hereinafter called CDA) and the Association of Canadian Faculties of Dentistry/L'Association des facultés dentaires du Canada (hereinafter called ACFD) are analagous; and

WHEREAS, a significant number of Active and Student Members of CDA are directly and indirectly represented by ACFD; and

WHEREAS, the majority of Canadian dental research is performed in

dental schools by dental faculty and the results from this research redound to the benefit of the dental profession and the public; and

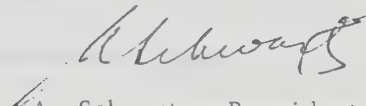
WHEREAS, undergraduate, post-graduate, graduate and continuing education is provided by faculty of ACFD member institutions and the effects from these educational endeavours are reflected in the high quality of preventive treatment dental services being delivered to the public; and

WHEREAS, it appears that a more formal sphere for interaction between CDA and ACFD would be beneficial to both associations; and

WHEREAS, no such formal sphere presently exists, therefore;

RESOLVED, that ACFD be recognized and granted one voting membership on the Board of Governors for CDA.

Respectfully submitted


A. Schwartz, President

REPORT ON HONOURS AND AWARDS

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

The intention of this report is to recommend the steps for the Association to take to achieve the following:

1. to recognize outstanding service to the profession by members of the profession and, in exceptional situations, by members of the lay public;
2. to impart a sense of history and tradition to the Canadian Dental Association which will be recognized and appreciated not only by our membership, but by anyone who associates, or does business in any way, with our Association.

The suggestions which follow are offered with the recommendation that they be implemented and that an annual review of awards and honours be made by the Management Committee of the Association with recommendations being forwarded to the Executive Council at the appropriate time. It is recommended that the Council on Nominations be consulted annually for their recommendations as well. It is also essential that the corporate bodies be consulted annually for nominations in any category of award for which the general membership or lay member of the public are eligible.

Committee and Terms of Reference

It is recommended that an Honours and Awards Sub-Committee be established, within the framework of the Council of Nominations, with the following terms of reference:

1. to continually monitor suitable categories and degrees of awards to recognize outstanding service to the profession;
2. to review annually the honours and awards system of the Association;
3. to recommend candidates for honours and awards to the Executive Council;
4. to receive, review and/or initiate nominations for the respective honours and awards;
5. to receive, review and/or initiate nominations for honours and awards for provincial or national organizations, be they dental or non-dental in nature;

REPORT ON HONOURS AND AWARDS

6. to ensure that all appropriate records of the deliberations in the area of honours and awards, together with records of the honours and awards granted, be kept at the Association office.

Awards

It is suggested that four categories of major awards be established: Honorary Membership, Distinguished Service Awards, Award of Merit and Certificate of Merit.

1. Honorary Membership

Honorary Membership is the highest award of the Association. Its purpose is to recognize the individuals deemed to have made outstanding contributions to the art and science of dentistry, or to the dental profession, over a sustained period of time. This award may be for service that is provincial, national or international in nature. It should in no way be viewed as an automatic award following a great number of years of practice and/or combination of above. Due to the distinctive nature of the honorary membership award, only in the most unusual circumstances will there be more than one or two awards conferred in any one year. An award each year shall not be considered a requirement.

Nomination

Candidates must be nominated by the Honours and Awards Sub-Committee with input and consultation with the corporate bodies and/or appropriate affiliated organizations. All nominations and supporting documents are to be reviewed by the Honours and Awards Sub-Committee and recommendations referred to the Executive Council.

Format: The format of this award should be a personalized parchment scroll, and an appropriate lapel medal.

It is proposed that honorary members (if they are licensed dentists) be exempt from payment of the CDA portion of the annual licence fee, but that they retain all of the rights and privileges of an active member. In addition, an honorary member and companion may attend both the scientific and social functions and the annual meetings and conventions held under the auspices of the Association without payment of a registration fee.

Presentation: This award shall be presented at a suitable formal occasion at the annual meeting by the President of the Association.

REPORT ON HONOURS AND AWARDS

2. Distinguished Service Award

This award may be given to a dentist or other person to recognize either an outstanding contribution in a given year, or outstanding service over a number of years. It may also recognize outstanding contributions to the dental profession at the corporate level, specialty society, council or committee level. An award each year shall not be considered a requirement.

Nomination

Candidates must be nominated by the Honours and Awards Sub-Committee with input from and consultation with the corporate bodies and/or appropriate affiliated organizations. Although it would be normal to present only one distinguished service award in a given year, it should be possible under exceptional circumstances to award more than one distinguished service award in a particular year.

Format: The format of this award shall be an appropriately engraved plaque.

Presentation: This award shall be presented at a suitable formal occasion by the President of the Association.

3. Award of Merit

The recipient of this award must be a dentist. The award will be conferred upon an individual CDA member who has served in an outstanding capacity in the governing of the Canadian Dental Association or for such other specific contribution to the organization, such as:

- at least 2 full terms as governor of the Association
- at least 2 full terms on the Executive Council
- at least 4 consecutive years of service to a component society or specialty sector
- at least 4 years as a Council/Committee chairman

A specific number of awards should not be mandatory in any given year. Automatic receipt of this award should not be assumed because of the fulfillment of any or all of the above requirements. An award in this category shall not be considered mandatory on an annual basis.

Nomination

Nominations in this category will be initiated by the Sub-Committee on Nominations, in consultation with various resources available to them.

REPORT ON HONOURS AND AWARDS

Format: The format of this award shall be an appropriately engraved wall plaque.

Presentation: The award will be presented at a suitable formal occasion, depending on the position and location of the recipient of the award. Wherever possible, the President of the Association or his designate will present the award.

4. Certificate of Merit

This award is to recognize any special service at any level of dentistry within the country. In general, it will be reserved for dentists and other persons who have given at least one full term of service in such areas as councils of the Association, or longstanding service at the corporate or special society level. An award each year shall not be considered a requirement.

Nomination

The Honours and Awards Sub-Committee will receive and review the nominations and/or nominate candidates. Nominations, together with any supporting documents, shall be referred to the Executive Council.

Format: The format of this award shall consist of a hand-lettered parchment scroll.

Presentation: The award shall be presented at a suitable formal occasion, depending on the position and location of the recipient of the award. Whenever possible, the President of the Association or his designate shall present the award.

5. Letter of Appreciation

A letter of appreciation will be written by the President of the Association to all other contributors at a committee or council level who do not qualify for the other awards by either time or qualification.

6. Past-President Award

Purpose: To recognize service and contribution as President of the Association.

Format: The format shall be a past-president lapel pin and an appropriately engraved plaque.

REPORT ON HONOURS AND AWARDS

Presentation: This award shall be presented at an appropriate formal occasion, whenever possible in conjunction with the annual meeting or convention.

Other Awards

1. Canadian Fund for Dental Research

- \$2,000 biannually
- To be presented at an official CDA function
- The recipient is to be funded to present the research paper at the ACFD/CADR biannual meeting, if he/she so desires

2. Universities

At present there are no CDA Scholarships/Awards at the university level. Laboratories, individuals, other associations and societies do have awards available through the universities. The following is recommended:

CDA President's Award

1. To be awarded to a graduating student in every dental faculty in the country
2. Amount to be \$250
3. Must be a student CDA member

Nomination

The winners are to be selected by each Faculty Awards Committee. Each winner is to be a graduating student from the undergraduate program who, over his/her undergraduate years, has shown outstanding qualities of leadership, scholarship, character, and humanity and who may be expected to have a distinguished career in the dental profession and society at large.

This award may be withheld on recommendation of a Faculty Awards Committee in the event there is no sufficiently qualified candidate.

Format: A cheque for \$250 plus a hand-lettered parchment scroll.

Presentation: To be presented to the winner at the graduating exercises by the CDA President or his designate, e.g. the dean.

REPORT ON HONOURS AND AWARDS

Source of Funds

A trust fund from donations and bequest, etc. could be established to provide \$2,500 - \$5,000 in scholarships per year. Approximately \$50,000 in seed money would be needed. In the event that the \$25,000 cannot be achieved through interest from trust funds in any given year, it is recommended that the funding be made up from general funds.

Respectfully submitted,

E.F. Allison, D.D.S.
Executive Council

ADOPTION OF REPORT

The Board of Governors accepts the report on Honours and Awards with appreciation.

EDITORIAL BOARD

REPORT TO THE ANNUAL CDA BOARD OF GOVERNORS MEETING
AUGUST 1986

Members: Dr. John Hardie, Chairman, Ontario
 Dr. M. Klotz, Ontario
 Dr. A.D. Sparrow, Alberta
 Dr. R.S. Turnbull, Ontario
 Dr. P.C. Desautels, Québec

1. Board Meeting

A productive meeting of the Editorial Board was held on April 18, 1986. In addition to the Board members, the following were present:

Ms. C. Hackland, Journal Editor, C.D.A.
Mr. C. Metcalfe, Journal Associate Editor, C.D.A.
Ms. A. Spencer, Journal Advertising Manager, C.D.A.

Items Requiring Board Action

2. Terms of Reference

Terms of reference for the Editorial Board were approved, and are attached in appendix I. The committee recommends:

RESOLVED:

86.47 THAT the terms of reference for the Editorial Board be accepted as amended.

ADOPTED

APPENDIX 1

3. Scientific Editors

The Board discussed the stipend paid to the Scientific Editors. Based upon an increased time commitment coupled with no increase for 10 years. The Board recommends:

EDITORIAL BOARD

RESOLVED:

- 86.48** THAT the stipend for the scientific editors be evaluated and upgraded to a level compatible with increasing costs and the time component required of those filling the role of scientific editors and that this be done in consultation with the scientific editors.

ADOPTED

4. New Features

The Board discussed the new regular feature which Dr. Crawford offered to write. Two relevant motions are recommended:

- i. THAT the purpose of any proposed regular feature be reviewed by the Editorial Board prior to publication in the Journal.
- ii. THAT the Editorial Board accepts in principle and welcomes Dr. Crawford's proposal for a column but recommends that each column be reviewed by the Membership Committee and be accepted by it before submission to the editor.

RESOLVED:

- 86.49** THAT any proposed regular feature be reviewed by the Editorial Board prior to publication in the Journal; that the Editor maintain control over issue-to-issue content of the Journal; and that the Editorial Board be consulted on any matter that would affect the long term content or format of the CDA Journal.

ADOPTED

5. Freelance Contract

The efforts of Ms. Hackland have created a freelance contract which will give the CDA world copyright to such articles printed in the Journal. The Board recommends:

EDITORIAL BOARD

RESOLVED:

- 86.50** THAT the final draft of the proposed agreement with freelance writers be accepted.

ADOPTED

A copy of the contract is attached in Appendix II.

APPENDIX II

6. Journal Circulation

The Board discussed the concept that the Journal was losing advertising revenue because of the policy of distribution to CDA members only. Concern was expressed that the Journal could be a more effective vehicle for attracting new members. After a lengthy debate the Board resolved and recommended:

RESOLVED:

- 86.51** THAT, for financial reasons, the Journal of the Canadian Dental Association be reinstated to full circulation to all dentists and that this be indicated as being a courtesy to non-members.

ADOPTED

RESOLVED:

- 86.52** THAT the CDA Management Committee appoint an Ad Hoc Committee on publications which will include representation from the current Editorial Board, Journal staff and the Council on Information Services, for the purpose of reviewing current CDA publications and making recommendations on their future terms and interrelationships.

ADOPTED

7. Editorial Staff Travel

The Board recognized that it is valid for the Editorial Staff to obtain and maintain a recognizable image within Canadian dentistry, therefore it is recommended:

EDITORIAL BOARD

RESOLVED:

- 86.53 THAT the Journal staff be encouraged to generate a higher profile vis-a-vis the various provincial associations and internationally, and that the necessary funding be considered as a valid budgetary item.

ADOPTED

Items For Information not Requiring Board Action

8. Journal Production Assistant

Anne Bisson has been hired to replace Ms. Cheryl Elliott.

9. Editorial Board Resignation

Dr. James Grier has resigned due to personal reasons. The chairman asked Board members to submit names of a replacement for discussion at the next meeting on Friday, the 24th of October.

10. David Woods' Contract

Ms. Hackland was advised to extend David Woods' contract as a freelance writer to December 1986.

11. Features Survey

Over the past year, a number of new features have been introduced in the Journal such as "Ad Lib", "Did You Know" and "Clinical Features". Ms. Hackland was asked to assess the attitude to these features by preparing a pertinent survey for distribution at the Halifax Convention.

12. Status Reports

Realizing that certain status reports prepared by Councils would be of interest to readers, it was resolved that the Council on Dental Materials and Devices and the Committee on Consumer Products Recognition be requested to forward to the Journal editor current status reports or materials, devices and products for possible development into articles for the Journal by the editorial staff in consultation with appropriate council members.

13. CDA Activities

In an effort to promote the numerous activities of the CDA, Ms. Hackland was asked to decide on the appropriate time to publish a synopsis of each councils' and committee's activities once a year in the Journal.

Respectfully submitted,

John Hardie, BDS, MSc, FRCD(C)

ADOPTION OF REPORT

The Board of Governors accepts the report of the Editorial Board with appreciation.

CURRENT TERMS OF REFERENCE

EDITORIAL BOARD

Terms of Reference:

THAT the terms of reference for the Editorial Board be as follows:

The Editorial Board of the Journal of the CDA shall be comprised of:

- a) the Executive Director
- b) the Editor
- d) the Scientific Editors
- c) four members in good standing of the CDA

The four dentists shall be appointed annually by the Executive Council to a maximum of six years; one of whom shall be appointed Chairman on an annual basis by the President.

The Editorial Board shall meet at least annually and the Editorial Board shall provide a report to the Executive Council annually.

The Editorial Board shall develop guidelines for the management of the Journal and its advertising content.

The Executive Director together with the Editor shall exercise full editorial control over the publication of the Journal in accordance with the policies of the Association.

Amended 09/84

TERMS OF REFERENCE

EDITORIAL BOARD

1. The Board is a standing committee of the Executive Council which represents the general CDA membership to ensure that the Journal is an effective, pertinent dental publication;
2. Board members shall be members in good standing of the Canadian Dental Association;
3. Board members shall be selected by Executive Council to serve for a term of office to be determined by Executive Council;
4. The Board shall consist of a Chairman, three members-at-large, the English Scientific Editor and the French Scientific Editor;
5. The Board shall meet at least twice per year, and shall report directly to the Executive Council;
6. The Board Chairman shall prepare a twice-yearly report for presentation to the Board of Governors meetings;
7. The Board shall make recommendations with regard to the fiscal, editorial, advertising, and content policies of the Journal of the Canadian Dental Association.

APPENDIX #2

THIS AGREEMENT made in duplicate as of the day of _____, 198 .

B E T W E E N:

THE JOURNAL OF THE CANADIAN DENTAL ASSOCIATION

hereinafter referred to as "JCDA"

OF THE FIRST PART

A N D:

hereinafter referred to as the "author"

OF THE SECOND PART

1. JCDA hereby employs and commissions the author and in consideration of the payments provided for by Paragraph 8 hereof, the author hereby undertakes to prepare for JCDA an article (herein called "the work") on the subject of

, the world copyright in which shall be vested
in JCDA upon completion of the obligations of JCDA under this
agreement.

2. The work shall have a desired length of _____ words with a maximum of _____ words and shall be prepared in a manner fit for publication and delivered to JCDA at its offices at 1815 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6, no later than _____.

3. The author will from time to time and within 10 days from receipt thereof, revise the work in the manner requested by JCDA.

4. The author hereby undertakes that other than for JCDA, he will not for a period of _____ after the publication of the work, publish without the written consent of JCDA any abridgment or part of the said work and that he will not prepare, publish or be in any way financially interested in or allow his name to be connected with the authorship, editorship or publication of any work of a nature likely to compete with it.

5. The author guarantees to JCDA that the work will not in any way whatever violate any copyright belonging to any other party and will not contain anything of a libelous character and undertakes to hold JCDA harmless and indemnified from all manner of claims or proceedings which may be taken or made on the ground that the said work is in violation or contains anything libelous.

6. If, in the opinion of JCDA, the author omits or neglects or becomes unable to perform the author's part of this contract, or neglects to complete the said work or any part thereof within the specified time, or omits or neglects to make

additions or alterations as hereinbefore provided, or if, in the opinion of JCDA, the work does not conform to the subject matter or style agreed upon, JCDA may (without prejudice to any other right or remedy) itself revise the work or procure the said work or the remainder of the said work to be performed by any other person at a reasonable remuneration and JCDA is hereby empowered to deduct the costs of same from any monies otherwise payable to the author under this agreement.

7. Notwithstanding the generality of the foregoing, it is understood and agreed that whether or not such revisions are carried out, JCDA may reject the work if, in its opinion, it is not suitable for publication in its Journal and in such event, JCDA shall not be liable to pay any or all of the amount hereinafter set forth.

8. Subject to the foregoing, JCDA shall pay the author at the rate of _____ cents per word, such payment to be made as soon as the acceptable work has been delivered to the printer.

9. Any disputes which may arise under or out of or in connection with this Agreement shall be submitted to the arbitration of two arbitrators (one to be appointed by JCDA and

the other by the author) who may appoint a third arbitrator and the provisions of the Arbitrations Act of Ontario shall govern the said arbitration. Any award made by the arbitrators or a majority of them shall be final and binding on the parties hereto and any persons claiming under them.

IN WITNESS WHEREOF the parties hereto have signed as of the date first above written.

SIGNED, SEALED and DELIVERED

in the presence of

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JCDA

Per:

Author

THIRD PARTY DENTAL PLANS COMMITTEE

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. D.E. MacFarlane, Chairman, Vancouver
Dr. D. Gutkin, Winnipeg
Dr. T. Gushue, St. Johns
Dr. W. Leggett, Brampton
Dr. R.J. Markey, Executive Liaison, Vancouver

Members of Alternative Delivery Sub-committee:

Dr. L. Allen, Winnipeg
Dr. B. Rocky, Vancouver
Dr. P. Vezina, London

1. Committee Meeting

The committee has met three times or six days of meetings since the last report to the Interim Board of Governors April 4, 5. The meetings were April 6, 7, May 31, June 1st and June 22, 23.

Liaison activities - the committee met with:

Blue Cross representatives on April 7

QDSA representatives on June 23
to discuss Dentaide and Societé de Services Dentaires
(S.S.O.)

Chairman met with:

Representatives of Sun Life
and representatives of Future Focus Capitation Plans

Items Requiring Board Action

2. Revision to CDA Uniform System of Codes & Lists of Services

The Committee recommends acceptance of the following codes, which was considered previously at the Interim Board of Governors.

THIRD PARTY DENTAL PLANS COMMITTEE

Revision to CDA Uniform Systems of Codes & Lists of Services (cont'd.)

RESOLVED:

86.54 THAT the CDA Uniform System of Codes & Lists of Services be revised as follows:

- (a) 52122 Partial denture, maxillary, acrylic base, resilient retainer
- (b) 52123 Partial denture, mandibular, acrylic base, resilient retainer
- (c) 65500 Metal onlay, acid etch bonded per abutment tooth - Pontic Extra

REFERRED

DIRECTION: The above codes as amended were referred back to the Third Party Dental Plans Committee for revision of definitions.

The Committee recommends:

RESOLVED:

86.55 THAT the New Codes - Implants be approved:

New Codes requested by the Alberta Dental Association

- 57700 Implants Endosseous;
- 57710 Implants Endosseous - maxillary, integrated, cylindrical;
- 57720 Implants Endosseous - mandibular integrated, cylindrical.

ADOPTED

Note:- We are continuing to review the entire list and when completed will be seeking your approval.

THIRD PARTY DENTAL PLANS COMMITTEE

3. Policy Statement

Dental Plans should not cause radiographs to be taken solely for administration of benefits.

In addition, the CDA has a concern about excess radiation, and adoption of the following resolution is recommended:

RESOLVED:

86.56 WHEREAS dentists believe that dental patients should not be unnecessarily exposed to radiation,

AND WHEREAS claims supervisors for dental insurers, in many cases, routinely require radiographs to be submitted in support of patient claims,

AND WHEREAS the dentist's professional judgement may not require radiographs for the purpose of patient treatment in such instances,

THEREFORE BE IT RESOLVED that the Canadian Dental Association express its concern that dental patients should not be exposed to radiation for the sole purpose of verification of eligibility for dental benefits or confirmation of treatment completed, and

THAT this position be communicated to the following:

- (i) the Dental profession across Canada
- (ii) federal and provincial Ministries of Health
- (iii) third party carriers of dental services
- (iv) federal and provincial superintendants of insurance
- (v) federal and provincial regulatory bodies
- (vi) The Consumers Association of Canada

ADOPTED

THIRD PARTY DENTAL PLANS COMMITTEE

4. Capitation Brochure

Note to Executive: Currently this is being prepared. The final brochure mockup with cost estimates to produce will be available shortly and forwarded to the Governors under separate cover.

RESOLVED:

86.57 THAT the document "Perspectives on Capitation" be approved, subject to proper editing.

ADOPTED

APP. I

5. CDA Policies on Prepaid Dental Plans

The policy manual is being revised. Due to workload the revision has not been completed for the Executive perusal. The committee would request we be able to include it in the Board Book for the Boards' approval.

The Board of Governors received the draft of this document for information.

Items for Information - Not Requiring Board Action

6. Budget

The Committee on Third Party Dental Plans is gradually increasing its activities and has informed Executive Council of its need for increased staff support. Separate budget estimates for 1987 have been presented to illustrate funds required to support the Committee's work (both with adequate staff support and without). At this time, it is understood that additional staff support is being provided and that budget estimates for CDA include provision to support the level of activity proposed for 1987.

7. Letter to CHLIA re Newfoundland position is attached for information.

APP. II

8. Report of meeting with QDSA on S.S.D. & Dentaire is attached for information.

APP. III

THIRD PARTY DENTAL PLANS COMMITTEE

- 5 -

9. Report on meeting with Future Focus is attached for information.

APP. I

Respectfully submitted

Dr. D.E. MacFarlane
Chairman
Third Party Dental Plans
Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Third Party Dental Plans Committee with appreciation.

Third Party Committee

Information on

Prepayment

Systems

A
Handbook
on
Capitation



PLEASE RETAIN FOR FUTURE REFERENCE

For ease of reading, masculine pronouns have been used throughout the document to represent both males and females.

Published by the Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

A Handbook on Capitation

INTRODUCTION

Capitation is being actively marketed in Canada. Eventually, every dentist may have to decide whether or not to join a capitation program. It's a tough decision.

The concept of capitation is an old one; its application to dentistry is relatively recent but it has spread rapidly in some parts of the United States. It is now being actively and aggressively marketed in Canada. It has become an issue no Canadian dentist can ignore. It has promoters and detractors and, like porridge, you either hate it or like it, or put up with it because you have to. It's not the sort of thing you can feel neutral about. Sooner or later many Canadian dentists may face the question of whether or not to join a capitation program. C.D.A. is providing this information brochure to help you make the right decision.

THE MECHANICS OF CAPITATION

Under capitation the dentist agrees to provide specific services for specific patients for a specific period of time for a fixed fee per patient, regardless of the amount of care required.

Not all capitation plans are the same but they must have some features in common if they deserve the name. Capitation plans involve a complex contractual or legal relationship between patients, dentists and the plan promoter. As a dentist participating in a capitation plan, you would be required to sign a contract. The contract will specify your rights and entitlements on the one hand and your responsibility and assumed restrictions on the other. Breach of the contract on your part could land you in court. The contract is between you and the plan promoter, which could be an insurance company, a firm specializing in marketing and operating capitation plans, or even an industrial corporation. In short, the other party to the contract will usually be "large" when compared to an individual dentist and have a strong economic interest in enforcing the contract.

Under a capitation contract the dentist agrees to provide the dental services required by a patient for a specified period of time. The services are usually identified in some type of attachments to the contract. Typically, the time period is one, two or three years. In return for agreeing to provide service to the patient, the dentist receives a monthly or annual fixed fee from the plan promoter. This fee does not vary with the number of services rendered. The dentist's total reimbursement from the plan promoter will vary only with the number of patients or "per head" (or sometimes family) — hence the expression "capitation".

This is the essence of capitation: accepting responsibility for the care of the patient for a period of time at a fixed monthly or annual fee. It is a radically different approach from traditional fee-for-service and has profound implications for both patient and dentist.

The capitation contract is a complex document. Plan promoters recognize that under capitation there may be a strong incentive for the dentist to "under-treat" patients. They therefore place in the contract a number of provisions designed to assure adequate, quality treatment. These provisions may place significant restrictions on how the dentist operates his practice. However, the very nature of the contract substantially alters the role the dentist plays in dental health care. It turns him into an insurer of last resort. He becomes the person who bears the risk.

THE MANAGEMENT OF RISK

All forms of capitation require the dentist to assume a degree of financial risk that is not present in the fee-for-service modality of payment. How this may affect dentists' behaviour is not known.

Economists tell us that risk arises because more things could happen than might be expected to happen. Insurance makes the future predictable in some sense. We acquire fire insurance because our house could burn down. If it does we are not then confronted with an unexpected cost. Our fire insurance premiums are predictable and, of course, have a cost, but we eliminate some uncertainty from our lives. The insurer bears the risk of the less certain but much larger cost of a fire.

Under capitation, the patient pays a premium, or has it paid on his behalf, to the plan promoter. This premium, like fire insurance, is paid to avoid risk. From the premium the promoter deducts his fees and profits and pays a dentist a fixed fee for the care of the patient. The promoter bears no insurance risk because his outlays to the dentist are predictable. The dentist, however, does not know what care the patient will require. His costs in caring for the patient are uncertain and it is this uncertainty that means that he has become the insurer. He will profit financially under the arrangement if little or no care is rendered (the house does not burn down) and he will suffer financially if a lot of care is required (the house does burn down). Assuming this risk creates a complex set of incentives and disincentives that previously have not been at play in dentistry.

CAPITATION FROM THE PATIENT'S PERSPECTIVE

Capitation is promoted as an attractive alternative for the patient but in fact, patients are already getting effective preventive care under existing fee-for-service insurance. For these patients capitation offers no benefits and some real risks.

The optimistic patient may look at a capitation plan and conclude that the dentist will want to do everything possible to avoid the need for extensive restorative treatment — that the dentist will pursue the cheapest and most effective preventive program he knows. If this happens, the patient is

“better off” because it minimizes the tissue loss and the need for restorative or remedial care. The dentist makes his living from promoting good oral health and not from treating disease. He does everything he can to prevent the house from burning down.

The pessimistic patient may look at the same capitation plan and conclude that the dentist will attempt to avoid rendering treatment and will do as little as possible. The outcome will be inadequate care or under-treatment. Here the dentist denies the house is burning down or looks the other way. Pessimistic patients of this sort would be happier to be treated under fee-for-service.

Clearly, those most enthusiastic about capitation must believe that the pattern of practice will change and change for the better through more effective preventive treatment. This view must be greeted with caution because there is substantial evidence that those routinely visiting dentists already receive effective preventive care. Thus, it must be questioned whether a switch to capitation would, in fact, change the mix of procedures towards more preventive care. The optimistic patient may be misplacing his optimism.

There is some evidence of patient dissatisfaction with capitation plans in the United States and of a return to fee-for-service arrangements. There have been problems with access to treatment and some suspicion of under-treatment. On the basis of available data, the pessimistic patient is the realist and correct in assuming some types of expensive restorative care will not be done.

A further concern from the patient's perspective is that the patient will inevitably lose some freedom in his choice of dentist. Clearly, his choice is limited to those dentists who have contracts with the plans and, in some communities, this may sharply reduce his choice. Once having selected a dentist and having been treated by that dentist he may not, without showing cause, be completely free to switch dentists, either because of restrictions on his own mobility or because other contracting dentists may be reluctant to accept a patient requiring treatment who has had a part of his monthly capitation fee directed to another dentist.

An unhappy encounter with the first dentist chosen may discourage utilization of the plan by some patients and therefore lead to less care and a deterioration in their oral health.

Lastly, patients, or those paying for employee benefits, should be concerned about the fees collected by plan promoters. These have been reported to range from 15% to 50% of the premiums; these are fees that are far in excess of the administrative fee charged under indemnity plans or cost plus, fee-for-service plans. This type of administrative charge is clearly excessive.

The patient must decide whether he will be better or worse off under capitation. This of course raises the question “Better off compared to what?” The comparison should probably be made between the capitation and fee-for-service indemnity insurance. In both cases the patient has all or a substantial part of the risk of unexpected dental costs removed.

The patient would be better off under capitation if there were something wrong with fee-for-service that is corrected by capitation. Two types of criticism have been directed at fee-for-service: first, it is alleged to be expensive and second, it may lead to over-treatment or too little regard for

preventive services. Neither of these allegations can easily be supported by the facts. In real terms, dentistry has become less expensive over the past few decades; so, if dentistry is expensive it is so only in the sense that we would all like to pay less for everything. The suggestion that there is over-treatment or too little regard for preventive services is even more difficult to understand. The reduction in the incidence of caries and the increase in the number of caries-free children is perhaps one of the most remarkable of all health care phenomena of the past 20 years. The wry suggestion that dentists are putting themselves out of a job has an element of truth in it. Given the successful attack on dental disease, it is questionable whether any attempt should be made to change the predominant delivery system. The present fee-for-service system is working very well — so well in fact that there is no evidence that the dental nurse programs in Saskatchewan and Manitoba (programs which have a very strong preventive element) lead to better oral health for children than does private dental practice.

CAPITATION FROM THE PERSPECTIVE OF THE PLAN PROMOTER

The plan promoter is the one party who may clearly benefit from the rise of capitation. It has been reported that in the United States plan promoters have retained between 15% and 50% of the patient's premium.

The interest in capitation does not come from increasing cost or from deficiencies in traditional oral health care plans. Rather, it comes from a perception that an opportunity exists for business to “bargain” with the dental team to get fee concessions. There is a perception that a deal can be made: that the entrepreneurs or plan promoters can provide the dentists with something in return for a cut in the dentist's usual and customary fees. What the entrepreneur hopes to offer is a captive patient pool. This raises two questions: what is a reasonable fee for a capitation patient and is it right for the patient to be “captive”?

THE CAPITATION CLOSED PANEL: THE PATIENT'S RESPONSE

Closed panels may lead to a decline in utilization and therefore to a decline in effective prevention.

If patients are now receiving high quality preventive care, what could they stand to lose in trading off a reduction in cost for the entry into a closed panel? Possibly, a great deal. Dentistry, more than any other health service, requires good rapport between the professionals and the patients to ensure the service is used; regular utilization of the dental team is the first step in effective prevention. The mobility of the patient is essential to his finding the “right” dentist. He should not be forced to choose between a limited number of dentists for his care but should be completely free to seek out the dentist of his choice. A very disturbing feature of capitation plans is the prospect of the disruption of well-established patient-dentist relationships. The loss of this relationship could lead to a decline in oral health because of suppressed utilization rates.

The second danger to the patient is that treatment patterns could change — for the worse. The present patterns have brought Canadians a remarkably high standard of oral health. The pressure of adjusting to the risk imposed on the dentists could lead to changes in the mix of procedures performed; how this may occur in the long run is not well documented. While the patient may free himself of financial risk in the short run, he may be assuming a subtler risk in the long run. He may be gambling with his own oral health. This is a major reason that CDA recommends extreme caution in your appraisal of whether or not to enter a capitation agreement. You should be especially concerned if a capitation plan does not offer the patient freedom of choice. The CDA strongly supports the dual choice option; that is, allowing the insured patient the choice between fee-for-service and capitation.

THE COST FACTOR

The cost of dental treatment can only be reduced if fewer services are performed (in which case the patient suffers) or if the dentist's income is reduced. Evidence suggests both of these effects have occurred in the U.S.A.

Promoters of capitation plans hold out the promise of lower premiums. This, as suggested earlier, means that fewer services will be provided — there will be a reduced care package — or that dentists will earn less. The plan promoters must believe that dentists will be willing to work for less in return for a captive patient pool. Of course, it is unlikely that you would be told to expect to earn less under capitation; in fact, the converse suggestion is likely to be made.

Plan promoters appear to emphasize two aspects of capitation: 1) that it may bring new patients into your practice; and 2) that gross monthly revenue will be more "predictable". The validity of both these suggestions is questionable and their inference misleading. First, capitation plans have been promoted largely among groups already receiving fee-for-service insurance. These will not be new patients to dentistry. New patients to your practice, if they come, are likely to come from someone else's practice and if plans spread you are likely to lose some as well. If capitation plans are "sold" on an individual basis they will most likely be bought by patients already under care, who are now paying for their dentistry on a private fee-for-service basis. The actual fees that will be paid to the dentist vary from plan to plan and depend upon:

- i) the services covered;
- ii) the provision for specialist treatment;
- iii) the degree, (if any) of co-payment; and
- iv) the policies and bargaining power of the plan promoter.

Currently, there is little public information about the proposed level of capitation fees in Canada. Generally, however, it appears that capitation fees represent a level of compensation substantially below current provincial association fee guides. Deciding whether to sign a capitation contract is a highly individual decision that should include advice from your lawyer on the implications of the contract. Your legal adviser will not be able to tell you whether it will be financially rewarding to sign the contract. That is a

personal decision, but there are some general considerations that should be borne in mind.

For dentists using provincial fee guides, the costs of operating a practice are typically 60%-65% of the gross revenues. Naturally, some are higher, some are lower. You should establish from your more recent financial statements your own ratio of costs to gross income. For illustrative purposes let us assume that it is 60%. A bit of simple arithmetic will suggest how a discount on fees translates into a discount on net income. Suppose fees are discounted by 20%, that is they are only 80% of the provincial guide or of your usual and customary fees, which we index or set equal to 100. This means that for every \$100 grossed \$40 would go to net income because expenses take \$60, that is $\$100 - \$60 = \$40$ net. With a 20% discount on gross fees we now have $\$80 - \$60 = \$20$ net so that a 20% reduction in fees results in a 50% reduction in net. Remember, lowering your gross fee will not lower your expenses but it will lower your net dramatically.

The second step in evaluating a capitation fee is to determine the procedures you will routinely provide under such a program. Again, a survey of your own records may be helpful but they may not provide all the answers. First, you must determine whether the patients who will come to you will be people who have been under high levels of care or people who may have a considerable backlog of treatment which must be done. The difference in treatment costs for these two types of patients can be very dramatic. You may have trouble properly estimating both the number and cost of treating patients with a backlog, but it is possible to develop some idea of the costs of patients on recall. Their pattern of care is much clearer, but at best, this is still an average approximation and your own experience may be quite different.

Example: Calculating a <i>Minimum</i> Capitation Fee for a Recall Practice		
Average Annual Procedure Mix Required	Cost based on the Ontario Guide (1986)	Frequency of Services
Recall Exams	\$ 21.61	1.35
Radiographs	\$ 12.89	1.37 films
Prophy & Scaling	\$ 91.89	2.42
Amalgams	\$ 66.60	1.48
Composites	\$ 36.65	.74
All Others (C&B, Surg, and other preventive & diagnostic services)	\$104.07	1.18
Total	\$333.71	

This example illustrates the typical frequency of procedures that may be expected from a regular patient — an adult who is seeking a recall exam about every nine months or so. For adults with good oral health it would be imprudent to expect that care levels, on average, would be anything less than this. Consequently, the "total" roughly represents the minimum annual fee that would compensate a dentist at the level of the Ontario Guide for an average recall adult.

Unfortunately, this average recall patient may not be a good guide for any individual dentist because the incidence of disease will vary with location, socio-economic bracket and age. It is necessary to compensate for these factors when considering an appropriate capitation fee. If your capitation

patients are likely to be older, low income, blue collar workers in a non-fluoridated area, treatment needs could be much greater than those suggested by the average recall patient procedure profile suggested here.

Some of the plans' promotional literature suggests that you can treat capitation patients at a significant discount because they are "new patients who will fill out your appointment book". The suggestion is made that relatively little additional expense would be incurred to treat these patients. In most cases, the validity of this claim is doubtful. Studies of dental economics indicate that, in a well run dental office, most expenses vary with the number of patients and the amount of treatment rendered. Over time, in an efficiently run office, the number of staff and auxiliaries, the number of chairs — hence space and rent — are adjusted to the volume of the practice. Usually, excess space, excess staff or other overhead resources, are quickly and appropriately reduced. Unless you are in the position of having excess staff and a significant amount of idle time, it is unlikely that you would be able to accept new patients without increasing your costs. If you think you can expand your practice without increasing costs you may find the following food for thought: studies of thousands of dental practices have found that the expense-to-gross ratio is relatively constant with a tendency to rise in very large practices. Therefore, if you do successfully expand your patient load without a comparable increase in costs, your achievement will be statistically unique — unless of course your expenses are unduly inflated for your current patient load.

If it is true that the costs of new capitation patients will probably be comparable to the cost of treating your existing patients, a reduction in fees through a capitation scheme will have direct impact on your net income. You may expect that, for every 1% decrease in fees, you will experience a 2 to 3% decrease in the associated net. Thus a 15% decrease would typically mean a 37.5% decrease in net. Would such a reduction in net provide a reasonable level of income?

From the latest Taxation Statistics, the average net income from a professional practice for a dentist in Canada in 1984 was about \$72,000 which, if adjusted for the fact that this is before provision for pensions and benefits, translates to a salary equivalent of about \$60,000. If this equivalent salary figure is reduced by 37.5% (which would result from a 15% reduction in gross fees), the salary equivalent from working under capitation would be roughly \$43,500, or about 20% more than a 1st Class Constable in most police forces in major Canadian cities. This is an income level the Constable could reach at an age when his counterparts in the dental profession are still in dental school.

Under typical job evaluation criteria this would not be a reasonable income differential. On this basis, it may be appropriate to consider how reasonable the implied net income under a capitation program is likely to be.

Many of the plan promoters actually suggest that not more than 20% of your patient load should be under capitation. With only 20% of your patients on capitation, the low level of implicit net income from capitation will probably be disguised. For example, an average net income of \$72,000 would fall to \$66,400 if 20% of the patients were put on capitation at an effective 15% discount in fees. Considering all the other dynamic changes taking place in dentistry and

the pressure on net incomes, the cause of this decline in income may be difficult to trace back to capitation.

Is there an answer to the general question, "What is a satisfactory capitation fee?" Because the answer depends on so many factors — the treatment requirements of the patients; the details of the plan; the nature of the practice; and of course, the dentist's income expectations — it does not seem possible to say that a particular capitation fee is necessarily reasonable and just. Unfortunately, it all depends!

In reaching a decision, the individual dentist should consult:

- i) his own financial statements;
- ii) his appointment book and the use of his time when not at chairside (remember running a practice requires that you have some time free for a variety of administrative duties and this usually means at least 3 to 4 hours a week);
- iii) the procedure mix of his average patients (this information may be available from surveys that you have participated in);
- iv) the type of patient who will be attracted by the particular plan and the likely utilization rate (because under such plans you may be paid for a patient even though he never presents himself for examination); and
- v) your target net income. You should consider the current level of your fees, your efforts and success in promoting your practice through recall programs, etc. You should also consider the potential for effective cost reduction, acquiring an associate, the staff mix, etc. With this information in hand you must then do your own arithmetic or seek the aid of a knowledgeable adviser who has some insight into the economics of a dental practice (possibly, but not necessarily, your accountant).

The economics of capitation are only one aspect of your problem. Capitation contracts contain a number of other provisions that can have a significant impact on your practice and your professional life.

GENERAL PROVISIONS OF THE CAPITATION CONTRACT

Capitation contracts vary and each will contain a number of detailed provisions. These should be thoroughly discussed with your lawyer and, in some cases, with your Registrar, because you may inadvertently place yourself in conflict with your professional act, regulations, or Code of Ethics. Upon close examination you may also find that the contract places unacceptable restrictions on your right to manage your own practice.

A capitation contract sets forth the rights and obligations of both the dentist and the plan promoter. Here are some of the things that you should carefully study:

- i) Who is covered, how do they identify you as their dentist and when does payment begin? It is obviously important that you know who will be covered by the agreement. You should attempt to determine whether they have previously been covered by a plan. This may provide a clue to the level of care they require (and expect).

The contract will usually indicate how the patient may choose a dentist and the time at which you would begin to be paid. In some cases the patient must identify "his" dentist at the beginning of the contract period and the dentist is paid from the beginning of the period. In other cases a patient may only become yours after an examination. You should also note whether there are any limitations on who the patient may choose and also whether you have the "right" to refuse to accept a patient or to limit the number of patients who choose you as their dentist.

It is also important to determine the conditions under which the patient, having initially chosen you, may change his mind and go to another dentist or, having initially seen another dentist, decide he wants to be treated by you. Under these conditions, it is important to know how or if the capitation fee will be split.

ii) What is the duration of the agreement, how will it be terminated or renewed and how will fees be revised during the terms of the contract? The contract will specify the duration of the agreement. Usually, this will be one, two or three years. It will also normally contain provisions under which either or both parties can withdraw from the contract. Both of these provisions have considerable economic significance. A short contract period could mean that you do a lot of backlog work only to see the patient disappear either because the plan is cancelled, the patient withdraws or the patient is subsequently treated by someone else. On the other hand there are obvious disadvantages to long contract periods in which you are "locked in".

The procedures to be followed at the time of termination or renewal are also important. You will want as much prior notice as possible if the plan is not to be renewed and since you may have made a considerable investment in some patients by taking care of backlog work you will want some assurance that you will be able to renew the contract on reasonable terms and for reasonable fees.

You should also recognize that once having signed a contract you may have put yourself in a relatively weak position when it comes to renewing the contract. If you have conscientiously "cleaned up" your patient pool the plan promoter may be able to find other dentists, or in fact propose to use his own salaried dentists to render treatment during subsequent contract periods. Obviously, the plan promoter will want to renew the contract at as low a capitation fee as possible and may use a variety of "threats" during negotiations with the dentist. If the dentist has become heavily dependent upon the plan, even if these threats are merely implied, they may force a dentist to accept a truly unsatisfactory contract. It is therefore very important to know what procedures will be followed to renew the contract before you sign the first contract. Remember, with the first contract you may be putting yourself in a fairly vulnerable position.

For contracts of greater than one year's duration you should also know if the fees will be revised during the contract period and how this will be done. Although inflation is now relatively low compared to rates experienced over the past decade, there are some forecasters who believe that the current low rates cannot be sustained. However, even if the rate of inflation runs at 4.5% a year for the next three years, at the conclusion of a contract entered into today, costs could be about 14% higher. Using the arithmetic discussed earlier, this could lead to an effective cut of about 35% in

net income by the end of the contract. Thus, mid-term revision of fees is important. Some promotional literature published by capitation plans claims that there will be no increases in premiums during the life of the contract.

iii) What provision does the contract contain to ensure that the patient will have access to dental services? It is usual for capitation contracts to contain a number of provisions to ensure that a patient requesting treatment or an appointment will be able to get it within a stipulated period. For example, one plan has a provision that requires the dentist to guarantee that a patient will be able to get an appointment within two weeks and that emergency service will be guaranteed to be available on a 24-hour - 7-day a week basis. Thus, if a dentist planned to be out of town he would have to ensure that an alternative (contract?) dentist would be available. Since the capitation patient does not pay for individual services, if he were treated by a dentist not part of the plan on an emergency basis, it could be the responsibility of the patient's regular dentist to compensate the acting emergency dentist.

Physical access to a practice is sometimes not enough. Some contracts require that, for the life of the contract, the dentist agrees not to change the location of his practice, alter his office hours or change his staffing complement in any way that would reduce the availability of service.

iv) How is quality of treatment assured and what provisions are made for inspection of the practice by the plan promoter? Plan promoters usually insist on the right to inspect or examine patients, records and the dental office. This would normally be done by other dentists hired by the plan promoter for that purpose. In some cases the contract requires that *all* the dentist's records be available, including those of patients not covered by the plan. The alleged purpose is to compare the treatment of those on fee-for-service with those covered by capitation to ensure that capitation does not lead to under-treatment. However, most provincial dental acts state that giving information concerning a patient's dental condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law is professional misconduct. Even if a "non-capitation" patient has signed a CDA Standard Dental Claim Form authorizing release of records to his insurer, the dentist does not have the right to release those records to any third party not directly involved with the funding of dental care for that patient.

Depending upon how the inspections or examinations are carried out, you may find that you incur some cost or inconvenience.

You should also clearly understand what procedures would be followed if either a patient or plan promoter were dissatisfied with some aspect of your conduct. The contract may contain penalty clauses and, of course, you may also have to face action by your professional disciplinary body. The contract will usually have some type of grievance procedure and you should get an opinion on whether the procedure conflicts with the disciplinary powers of your professional licensing body.

v) How are specialist services to be handled? You need to know under what conditions you will be able to refer a patient to a specialist and how the referral will affect

your own level of compensation. Several different procedures are now operating in the United States to handle referrals. The procedure may require "prior approval" before a patient can be referred; the cost of the referral may be covered under other provisions of the plan and not affect your fee or it may, in whole or in part, be deducted from your compensation.

It is also necessary to know to whom you will be allowed to refer. In some cases it may only be possible to refer to specialists who have a contract with the plan. You must also ascertain whether the contract would require you to perform procedures that you normally refer.

vi) What procedures are covered? As part of the contractual agreement there will be a list of covered procedures which must be performed or alternatively, perhaps, a list of procedures that will not be covered by the plan. Either way, there will be procedures which are totally excluded and for which the patient may be billed directly. In some contracts this may only occur under special provision or with the permission of the plan promoter. Some plans permit a form of balance-billing for some procedures. For example, for more expensive and sophisticated procedures, such as crown and bridge, the plan may permit direct billing to the patient of 30% of the provincial fee guide. Thus, while the procedure is not excluded from the plan, signing the contract legally constrains you in the way in which you are able to bill for it.

CAPITATION CONTRACTS AND PROFESSIONAL ETHICS

Some capitation contracts may contain provisions that are in conflict with or contravene provisions of your Dental Act, regulations or By-Laws under the Act or your Professional Code of Ethics.

Because dentistry is a self-governing and licensed profession, the professional conduct of dentists in each province is subject to a variety of legal constraints. The constraints and requirements that will define acceptable professional conduct in your province will be found in the relevant Dental Act, regulations made pursuant to the Act either by the licensing body or Minister of Health and by the Code of Ethics. The restrictions placed on a dentist vary from province to province and what may be an acceptable contract in one province may contravene regulation or legislation in another.

In some provinces, some capitation contracts may be construed as assisting an unauthorized third party to practise dentistry as a corporation and therefore conflict with existing regulations. The same contract in another province may be perfectly legal. Before you sign a contract you should study your Act, Regulations and Code of Ethics and consult a lawyer to determine whether you may be contravening any of the legal provisions that apply to you.

For further information contact your provincial dental association or the Canadian Dental Association Third Party Dental Plans Committee. Both the Committee Chairman and the Coordinator may be reached by contacting:

The Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6
(613) 523-1770



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

June 17, 1986

Mr. Kent G. Cook, Director,
Insurance Operations
Canadian Life & Health Insurance Association Inc.
20 Queen Street West, Suite 2500
TORONTO, Ontario
M5H 3S2

Dear Kent:

RE: Newfoundland Dental Association Policy on
Dental Consultants and X-ray Interpretation

The Third Party Dental Plans Committee of the CDA met on May 31st-June 1st and discussed the concerns of your association as presented during our meeting with CHLIA representatives on May 12, 1986. We have been informed that the position taken by Newfoundland is as follows:

If a dental consultant involves himself in reviewing radiographs or models, he is involving himself in diagnosis and/or treatment planning and is practicing dentistry and therefore must be licensed to practice in Newfoundland and subject to the Newfoundland Licensing Board.

Newfoundland generally follows the CDA policies in dealing with requests from dental plan carriers. In pretreatment situations, it is expected that pretreatment radiographs or models should be made available at the request of the carrier's dental consultant. The dental consultant making the request must be named. Such pretreatment situations include planned treatment of inlays, onlays, crowns and/or bridges. To our knowledge there are no other circumstances when dental plan carriers need or should receive dental radiographs.

It is also noted that CDA has a concern about radiation as presented in the following resolution to be considered at the Annual meeting of the CDA Board of Governors in August:

WHEREAS dentists believe that dental patients should not be unnecessarily exposed to radiation,

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AND WHEREAS claims supervisors for dental insurers, in many cases, routinely require radiographs to be submitted in support of patient claims,

AND WHEREAS the dentist's professional judgement may not require X-rays for the purpose of patient treatment in such instances,

THEREFORE BE IT RESOLVED that the Canadian Dental Association express its concern that dental patients should not be exposed to X-radiation for the sole purpose of verification of eligibility for dental benefits or confirmation of treatment completed, and.

THAT this position be communicated to the following:

- (i) the Dental profession across Canada
- (ii) federal and provincial ministries of Health
- (iii) third party carriers of dental services
- (iv) federal and provincial superintendents of insurance
- (v) federal and provincial regulatory bodies covering the administration of X-radiation
- (vi) The Consumers Association of Canada

The Newfoundland dentists, in their expressed position on X-rays, have moved further and more quickly than the CDA. It has been verified, however, that their position was adopted after a number of inappropriate requests by dental carriers administrations.

Enclosed are copies of some correspondence illustrating this:

- 1) Crown Life letter to Dr. B. Bowden, Jan. 28th paragraph 3, "as claims adjudicators are trained to assess the X-rays...".

Only dentists are licensed to interpret dental X-rays in Canada.

- 2) In your letter to Dr. T.J. Gushue of April 18th in the third paragraph on the first page you outline your understanding about the handling of X-rays. You state "We noted at the January meeting that knowledgeable claims staff may determine, under the supervision of the dental consultant, that pre-treatment X-rays are

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required to evaluate the carrier's liability for benefits, and may request such X-rays on behalf of the dental consultants. When they are received it may be evident that the pre-determination can be completed or the claim approved for payment without a detailed interpretation of the X-rays. In the interests of providing prompt service and relieving the dental consultants of routine non-productive burdens, the pre-determination or claim is approved in that way. If on the other hand an interpretation of the X-rays is required to determine the insurer's liability under the terms of its contract, then that interpretation must be done by the insurer's dental consultant, as spelled out in the CLHIA/CDA guidelines."

The Third Party Committee generally agrees with your position, except that any request must name the dental consultant. Any interpretation of radiographs should only be done by the dental consultant, when required to determine patient eligibility for coverage for those services outlined in paragraph two above.

The problem in Newfoundland arose because (1) no dental consultant requested the radiographs and (2) the claims staff are said to be trained to assess radiographs.

The final letter illustrates a case from Nova Scotia, involving the Manufacturers Life Insurance Company requesting X-rays for treatment other than for inlay/onlay/crown and bridge situations (and then denying payment for treatment of routine restorations needs). The dental consultant, on the basis of inadequate information, felt there was no need for treatment. If the consultant had some external reason to suspect overtreatment or inappropriate diagnosis he should have sent that information to the licensing board for peer review.

The Third Party Committee of CDA following a full review of all of the circumstances touching the Newfoundland position, requests that your association outline to its members that radiographs should be requested only in the limited pretreatment situations identified. In the case just noted, the consultant is based in Ontario and cannot be brought, to explain his actions, before the Nova Scotia Board. Such cases illustrate the frustrations that have lead to the decisive action by Newfoundland.

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Your association is concerned that if the Newfoundland policy stands other provinces will introduce a requirement that consultants be licensed in the province involved. This is unlikely to occur if carriers request X-rays in the fashion suggested and for the purposes identified.

Consequently, the Third Party Dental Plans Committee supports the position of the Newfoundland Dental Association.

The Committee suggests that those companies with plans covering clinics in Newfoundland obtain the services of a Newfoundland dentist to act as dental consultant. The Newfoundland Association would be happy to assist in identifying dentists willing to assume this responsibility.

We understand too the possibility that CLHIA may approach the provincial government. It is also possible, as noted during our meeting, that some member companies might withdraw entirely from the Newfoundland marketplace. The dentists of Newfoundland, however, feel their position is defensible and in keeping with current provincial philosophy on establishing the rights of the residents of Newfoundland vis-a-vis national corporations.

They also feel that some companies, which virtually never request radiographs or models to assess claims liability, are essentially untouched by the new policy.

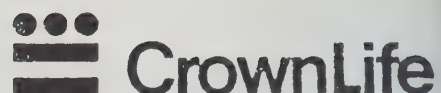
We realize this is not the solution you had hoped for, but it is the considered decision and I would be happy to elaborate upon it at your convenience.

Sincerely,

D. E. MacFarlane, D.M.D.,
Chairman
Third Party Dental Plans Committee

DEMacF/le
Encls.

c.c. Mr. Don Pamenter, Executive Director, Nova Scotia Dental Association
Dr. Brian Barrett, Executive Director, Prince Edward Island Dental Association
Dr. Jack Thompson, Executive Director, New Brunswick Dental Association
Dr. Bruce Bowden, Registrar, Newfoundland Dental Association



January 28, 1986

Dr. B. L. Bowden
203 LeMarchant Road
St. John's, Newfoundland
A1C 2H5

RE: Patient: Ann Webb
Policy#: 55937
Cert. #: 111 189 577
Pre-treatment plan for crowns on teeth #1-2, 1-1, 2-1 and 2-2

Dear Dr. Bowden:

In response to your letter dated January 13, 1986:

Although we appreciate your readiness to submit x-rays directly to our dental consultant, please understand that it is our standard office procedure to request that x-rays be sent to us first.

As claims adjudicators, we are trained to assess the x-rays to determine our liability for authorization of major dental treatment. If there is any doubt, they are then referred to our dental consultant for review.

Please be assured that these x-rays will be returned directly to you when our use for them has been satisfied.

As Ms. Webb's claim is being held pending your reply, a response to our previous request for x-rays would be greatly appreciated. We look forward to your reply.

Sincerely,

CROWN LIFE INSURANCE COMPANY

Gale F. Clarke
Group Claims Department

Crown Life
Insurance Company

CALGARY GROUP OFFICE
910 - 7th Avenue, S.W., Suite 760
Calgary, Alberta T2P 3N8
Tel. 403-269-6126 • Telex 038-24800



Canadian Life and Health
Insurance Association Inc.

FEB 18 1986

February 12, 1986

Mr. Don Pamenter
Executive Director
Nova Scotia Dental Association
2745 Dutch Village Road
Suite 205-206
Halifax, Nova Scotia
B3L 4G7

Dear Don:

Thank you very kindly for your letter of January 30th, 1986 in respect to radiograph interpretation issue.

I had been under the impression this matter had been resolved earlier in the year but have confirmed with Great-West that the intent of the Guidelines has been clearly explained to their staff in Halifax. Incidentally as I noted during our conversation, Great-West is monitoring the volume of dental business handled by the Halifax office and feels it may soon be practical to consider employing a dental consultant in that location.

My own reading of the Guidelines is it is quite in order for the claims reviewer to ask for the radiograph from the dentist. I think this makes practical sense for it would little serve the patient/insured, in terms of claims handling, to have the claims reviewer, either wait for the dental consultant to come into the office to write to the dentist for the radiograph, or to have the claims reviewer write to Winnipeg to have them write to the dentist. In most cases when the radiograph is received, the claims reviewer will be able to pay the claim. However, the real issue arises when the claims reviewer is unable to determine liability. This, of course, is where the dental consultant comes into play and in those cases where any doubt exists the expertise of the consultant should be sought. This is clearly Great-West's intention and is the standard procedure employed within the industry. Interestingly the Guidelines while quite specific as to the role of the dental consultant, don't make it clear that it is quite in order for the insurer, when no area of doubt exists, to go ahead and pay the claim. I wonder if perhaps we shouldn't add a note to the Guidelines to that effect.

.../2

Page 2.
Mr. Don Pamenter
February 12, 1986

You mentionned in one of your pieces of correspondence to Great-West that you wondered if the claims reviewer was acting as a dentist. I do not believe this is the case. The claims reviewer and indeed the entire claims process is designed to enable the insurer to determine its liability. It's quite hard enough to be an insurer in this age, I don't believe our fellows want to be dentists as well.

As always it was a pleasure to talk to you and I look forward to seeing you the next time I am in Halifax.

Yours respectfully,



Kent G. Cook
Director, Insurance Operations

KGC:nr



Canadian Life and Health
Insurance Association Inc.

April 18, 1986

Dr. T.J. Gushue, DDS
Executive Secretary
Newfoundland Dental Association
205 Le Marchand Road
St. John's, Newfoundland
A1C 2H5

Dear Dr. Gushue:

I read with concern the directive given to your membership which you enclosed with your letter of April 8, 1986. It was my understanding at the meeting of the private insurers' Inter-Industry Task Force and representatives of the Canadian Dental Association at the end of January, which you attended, that the problem of pre-treatment x-rays had been discussed and settled. To issue a directive, such as that contained in your letter, will have the impact of denying residents of the province of Newfoundland the opportunity to avail themselves of insurance coverage for which they have paid.

As discussed at that meeting, it is our understanding that insurers are following the guidelines agreed to by CLHIA and the Canadian Dental Association, as outlined below. If you are aware of specific instances where existing practices are not in compliance with these guidelines, and where x-rays are being used to limit a carrier's liability without proper interpretation by a dental consultant, we would like to investigate these and discuss these practices and the relevant guidelines with the insurer(s) involved as well as with your association.

We noted at the January meeting that knowledgeable claims staff may determine, under the supervision of the dental consultant, that pre-treatment x-rays are required to evaluate the carrier's liability for benefits, and may request such x-rays on behalf of the dental consultants. When they are received it may be evident that the predetermination can be completed or the claim approved for payment without a detailed interpretation of the x-rays. In the interests of providing prompt service and relieving the dental consultants of routine non-productive burdens, the predetermination or claim is approved in that way. If on the other hand an interpretation of the x-rays is required to determine the insurer's liability under the terms of its contract, then that interpretation must be done only by the insurer's dental consultant, as spelled out in the

.../2

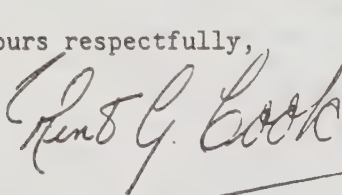
Page 2. —
Dr. T.J. Gushue, DDS
April 18, 1986

CLHIA/CDA guidelines. There seemed to be agreement with these procedures at that meeting, and I expected that any concerns about them or any evidence that they are not being followed would have been raised as a topic for further discussion, either at a future meeting between CDA and CLHIA representatives, or separately if the circumstances warranted. In the light of that recent discussion, your directive is a very surprising development.

With respect to insurers having consultants domiciled in each province, I would point out that the consultant's role is to help the insurer determine its liability. It is therefore apparent, at least to us, that the consultant needs to be completely familiar with the insurer's contracts and their provisions, the manner in which they are being administered and with the insurer's operating procedures, and that this only may be done effectively in the insurer's offices. That may mean that a consultant could be working at the insurer's head office regardless of the province in which the insured person is located or at a claim service office. I fully concur that the role of the insurer is not to dictate proper or appropriate dental practice procedures or treatment but I have to tell you that it is my strong belief that it is equally improper for the Newfoundland Dental Association to try to dictate to insurance companies their hiring procedures.

I am very disappointed that a directive of this nature would have gone out without discussion with either myself or my colleague, Charlie Black. Under the circumstances, I am unsure as to how you propose to proceed to ensure that Newfoundland insureds are not denied the ability to claim under the provisions of policies for which they have paid or their employers have paid. May I suggest an early meeting should be held to resolve this critical and important matter.

Yours respectfully,



Kent G. Cook
Director, Insurance Operations

KGC:nr

c.c.: The Hon. M. James Russell
Mr. Ambrose M. Hearn
Mr. Thomas F. Fagan
Dr. D.E. MacFarlane ✓

(a) Report on June 23, 1986 Meeting with Q.D.S.A. and S.S.D. Representatives
To Discuss Dentaide

Present: Dr. Claude Chicoine, President to QDSA
Mr. Yvan Brodeur, Chairman of Board of S.S.D.
Dr. Daniel Pelland, QDSA
Mr. Clermont Girard, actuary, QDSA

Dr. Chicoine outlined the background which brought him
and the Board to the decision to create Dentaide.

- | | |
|---|----------|
| 1. Background | APP. I |
| 2. Objective | |
| 3. Review of how current system was working | |
| 4. How S.S.D. would function to accomplish the objectives | |
| 5. How S.S.D. would provide the needed lines between Dentists and Insurance Companies | |
| 6. Summary of Actual Private Insured Dental Plans | |
| 7. Summary of Dentaide plan | |
| 8. Administration Implication in Dental Practice | |
| 9. Summary graph of the forces impinging on the dentist in his practice and SSD with its Dentaide plan. | |
| Service Contract between Dentist and S.S.D. | APP. II |
| Brochure for Dentaide | APP. III |
| Articles for Dent Pour Dent re: Changes Facing Dentistry | APP. IV |

(b) Report on June 23, 1986 Meeting QDSA + Joint CDA Third Party + Alternative

Development of a Dental Plan for Individuals

In an attempt to improve accessibility to care the QDSA identified a need for individual dental plans the QDSA via S.S.D. and two private insurers : Blue Cross of Quebec and Assurance vie Desjardins are developing a program that will be targetted at the age 16 - 25 year old group in the population. But would be available to others as well.

Currently the government regime for children covers them to age 15.

Government Regime

0-11 yrs.	Preventive Care provided in schools - plan pays for diagnosis, surgery, restorations, endodontics
12 yrs.	as 0-11 + preventive
13-15 yrs.	only preventive + diagnostic

In the individual plan could offer 13-15 yr. age group surgery, restorations and endodontic services to complement the government plan.

16-25	Basic Treatment	100%	
	Other Services	60% paid by Dentaide	40% by patient

In the beginning no coverage - for orthodontics or prosthetics

Included with the Dental Plan in the individual plan will be other insurance components which have not been completely worked out. But likely will include some life, extended health, etc.

It would also offer conversion possibilities for people leaving an employer with dental plan benefit to go to an employer with no group dental plan. They could convert to the individual plan.

Contract will be designed so that once you are in it will be in your interest to stay covered.

(b) Report on June 23, 1986 Meeting QDSA + Joint CDA Third Party + Alternative (cont'd.)

The subsequent years if you stay covered, the benefits will improve and likely if you get out you will never be allowed to come back in to the individual plan or there will be a financial penalty. One of the companies involved have the school accident insurance package so they will be naturals to convert the 13 - 18 age group as they already have the names and addresses of a large percentage of the school age population.

This plan will also use the Dentaide card and be administered by S.S.D.

Should be available by October 86.

Committee in Quebec is currently working to ensure the individual plan premiums will be tax deductible benefit.

Claim Form CDA Standard

- We will send English version.

Work for joint effort on French version - Claude Chicoine said he would be happy to assist.

Unique Numbering System

- Quebec government uses a special number to designate dentists - 20 because it also pays other health professionals under different codes. This makes it impractical for Quebec to use the CDA unique identification number system.

The committee feels this approach has a great deal to recommend it. Currently 1200 dentists are participating dentists and the coverage has grown to 70,000 people. More insurance carriers are becoming interested. By offering 100% basic coverage it provides excellent accessibility to seek treatment. The dental insurance carriers keep a small percentage for handling the marketing yet they do not have to maintain an administrative center for dental claims processing or adjudication. The dentist pays 2% of the fees which is a reasonable charge consistent with the charges by the credit cards i.e. Visa and Mastercard. In addition to fund the development of Dentaide each dentist initially paid \$800., now the fee is \$1,000.

There is clearly some resistance on the part of Quebec dentists to support and promote this concept. The committee will look into these criticisms and see if these are valid objections.

(b) Report on June 23, 1986 Meeting QDSA + Joint CDA Third Party + Alternative (cont'd.)

In the province of Quebec where there isn't the number of people covered by dental insurance that there is in other provinces the timing is right, the plan is imaginative and flexible.

As the coverage grows a greater percentage of the sensitive data on dentists will remain in the hands of organized dentistry not the insurance industry.

There will be concerns expressed about the potential to profile dentists practices and through this vehicle about controls. The design of Dentaide + S.S.D. does not establish profiles. If any concerns surface about billing practices, potential abuse, etc. these are turned over to an internal committee of 3 dentists, if this doesn't clarify it will be sent over to the Order of Dentists of Quebec for peer review, and if warranted discipline.

If Dentaide is successful at bringing large numbers of patients into dental plans who have not had coverage before the manpower oversupply will be reduced and the fuel to supply alternative (underemployed dentists) will be much less available.

The committee feels the CDA and the provincial associates and licensing boards should take a close look at this system.

Dr. Chicoine offered any assistance to any other province. The software package being available would greatly shorten start up time for anyone else interested.

It will be necessary to assess dentists in your province \$800 to \$1,000 to establish start up funds but this seems a very realistic cost to provide a system that provides professional control over our data, adequate competition in the marketplace to maintain excellent dental plans with fair fees and accessibility to the public for better dental health care.

June, 1986

DENT POUR DENT

Les défis de notre futur

APP. I

Notre système de dispensation de soins est indéniablement en pleine mutation. Les valeurs traditionnelles telles que le libéralisme, l'autonomie, la poursuite de l'excellence, le libre choix, pour n'en nommer que quelques-unes, se dégradent, se diluent, se transforment et sont sujettes à réinterprétation dans ce raz-de-marée du consumérisme.

Que l'on parle de **modes de dispensation de soins**:

- techniciens aux fonctions élargies ("dental nurse", "dental therapist", hygiéniste, denturologiste);
- cliniques de centres d'achats; ou de **modes de rémunération**:
- cession des bénéfices;
- capitation;
- P.P.O. (Preferred Provider Organization);
- cliniques de syndicats;

ou même de l'établissement de **profils de pratique par les compagnies d'assurances**, dans leur tentative de contrôler notre profession:

ces facteurs ont un dénominateur commun: la **recherche d'un moyen plus économique** pour contrer la hausse vertigineuse des honoraires des dentistes.

La profession a oublié cette remarque importante du préambule du guide des tarifs: "Si des étapes en sont éliminées, le facteur temps et les honoraires sont réduits en conséquence."

En termes clairs, si l'on a le droit d'exiger des honoraires supérieurs lorsqu'un acte est plus complexe que la normale, on a aussi le devoir de diminuer ces honoraires lorsqu'on a économisé du temps par la dispensation de soins multiples.

Même si nos arguments, à savoir nos coûts d'opération et d'équipement, sont fondés, il n'en reste pas moins que la population, qu'elle soit négligente ou motivée, ne peut plus suivre la montée de nos honoraires.

On observe donc les réactions suivantes:

- Le gouvernement cherche une solution, sans toutefois tenir compte de la qualité. Pourtant,

le gouvernement et notre profession partagent le même objectif fondamental: le mieux-être de la population. C'est dans la réalisation de cet objectif que nos chemins se séparent.

Pour lui, ce mieux-être est atteint quand il y a dispensation de soins à l'ensemble de la population, au meilleur coût, mais sans souci réel de la qualité. Cela signifie: mieux vaut des "dental nurses" ou des techniciens que rien du tout. Il en résulte que les politiciens tranchent la question en recherchant leur objectif premier: se faire élire.

Pour nous, le mieux-être de la population part des mêmes principes de base, mais suppose nécessairement un maximum de qualité, indépendamment du coût.

- L'entreprise privée, ne possédant pas le pouvoir de légiférer, ne peut, pour tenter d'épargner, s'attaquer aux modes de dispensation de soins de la même façon. Elle tentera donc une mainmise sur nos honoraires.

(suite en page 2)

The challenge of our future

Our dental care dispensation system is undergoing rapid and undeniable change. Traditional values such as professionalism, autonomy, pursuit of excellence and freedom of choice, to name a few, are being eroded, diluted, transformed and reinterpreted in this tidal wave of the age of consumerism.

Whether one speaks of the **method of distributing care**:

- dental nurse, dental therapist;
- denturologist;
- shopping centre or franchise clinic; or the **method of remuneration**:
- assignment;
- capitation;
- P.P.O. (Preferred Provider Organization);
- union clinic;

and even the establishment of **practice profiles by the insurance companies** in their attempt to control our profession;

all these entities have one common denominator: **the search for**

a more economical way to counteract the dizzying rise in dental fees.

The profession has forgotten this important remark of the Suggested Fee Guide: "If steps are deleted then the time factor and professional fee must be reduced accordingly".

In clear terms, it means that if we have the right to increase our fees should unusual complications arise, we also have the duty to decrease our fees when multiple services are involved thus significantly reducing the time factor.

While operating and equipment costs can be put forward as reasons, it is nonetheless true that the public, whether negligent or motivated, just cannot keep up with our climbing fees.

We are thus observing the following reactions:

- Governments look for the solutions without regard for quality. All governments, like all professions, share the same objective: the public's well-being. But

where their paths part is in the application of this philosophy. For a government, this well-being is achieved when health care has been provided to the population as a whole at a minimum cost but without regard to quality. This signifies that, in their view, dental nurses, technicians and therapists are better than nothing. The politicians make their decisions based on concern for their primary objective: to get elected. For our profession, on the other hand, the public's well-being starts from the same basic principles but with maximum quality, independently of the cost involved.

- Since private enterprise does not have the power to make laws, it cannot change the health care distribution methods to try to save money. So it will tackle the fee problem directly by favoring assignment or implementing capitation, P.P.O. and, a brand-new invention, Union Clinics.

(continued on page 2)

Journal mensuel publié par le comité des communications de l'Association des chirurgiens dentistes du Québec

Volume 11, numéro 3

Montréal, mars 1986

The challenge of our future

Since we have already discussed the assignment issue, we will now deal with the other remuneration methods.

Capitation

Capitation is an alternative to the fee-for-service procedure. It is a prepayment system by which the contracting dentist is compensated at a fixed rate per patient or family of patients (per capita), in return for a signed agreement to provide specific, predetermined dental services, when appropriate and necessary, to eligible subscribers. Capitation payments are based upon the number of persons eligible for dental benefits, whether or not dental services have been provided to these subscribers.

Subscribers are eligible for benefits under the program only if treatment is provided by a con-

tracting dentist. Each contracting dentist is usually responsible for referral and associated costs of specialty services and for emergency treatment for his capitation patients.

Due to the fixed nature of dentist reimbursement, the contracting dentist is assuming the financial risk of underwriting the capitation program. This risk is that the cost of actual services provided to subscribers of the program, may exceed the capitation payments. If it does, the contracting dentist suffers a financial loss. If actual costs are as projected or less, the contracting dentist realizes a financial gain.

Some capitation programs claim to employ an internal review process and periodic clinical and/or record reviews in order to monitor and evaluate the professional services rendered. A dentist

may have to modify his record keeping system in order to conform to the necessary review requirements.

Capitation is not a purely theoretical view, it made its appearance in the Hamilton area. This has already become a major concern for the Ontario Dental Association. And we have learned that the dentists in Alberta and Nova Scotia are also preoccupied by the possibility that capitation may be implemented in their provinces.

Preferred Provider Organization

This procedure provides the dentist with the opportunity to remain in a fee-for-service setting. It is based on the dentist agreeing in advance to accept discounted fees for services provided to a given group of insured persons,

in exchange for publication and distribution of the dentist's name to all members of the insured group.

The insured patient has a free choice of his dentist, but he will of course be inclined to choose a contracting dentist whose name appears on his list.

The essence of this program is to provide the patient with an economic incentive (the discounted fee schedule) to seek care from a contracting dentist, thereby incurring a lesser out-of-pocket financial obligation.

Since the only patient benefit of this model is access to dentists who have agreed to provide care at reduced fees, the contracting dentist is not assuming an insurance risk, as with the capitation program.

However, several factors may have a significant effect on the fi-

nancial success of this arrangement for an individual dentist:

- 1) Treatment must be provided at a discounted fee to members of the subscriber group, even if they are already patients on record.
- 2) The contracting dentist will now have two sets of usual fees — discounted and undiscounted.
- 3) People talk to one another and the dentist may find himself in an uncomfortable position when a discussion of fees take place. This will have an effect on his "customary" fee that he may also have to reduce.

In this scheme, the contracting dentist will need to consider potential reaction of non-subscribing patients to the reduced fee arrangement and establish a clear and concise position in the explanation of this perceived discrimination.

Participation in this type of con-

tract usually requires that the dentist be subject to an extensive utilization review program. This typically involves generation and maintenance of a dental procedure data base created from submitted dental claims. From these data are created profiles of practice and carriers or employers tend to dictate their norms of practice.

In the United States, some organizations which promote this type of contract, after reviewing the dentist's practice patterns, take disciplinary action if they consider it appropriate.

In Quebec, even though the dentist is placed in conflict with his code of ethics by agreeing to practise within this context, this did not prevent the Mitel company of Bromont from urging dentists in that region to join this health care dispensation sys-

tem. Dentists who agree to follow this path do not seem to realize that this is a first and irreversible step towards control of their fees by third parties.

Union Clinics

In August 1985, the Canadian Federation of Labour intended to set up Union Clinics for dental care for its members.

This system is very simple: the Union hires a dentist on a salary basis. If there are not enough patients to make a profit, there is a possibility that this service be offered, at a reduced fee, to the public.

In British Columbia, a dental insurance carrier, CU & C, is planning to open a dental clinic to service its client companies and possibly the general public. In Manitoba, Unions have taken upon themselves to make a survey of

dentist's fees.

The private enterprise becomes involved in our remuneration methods and goes as far as establishing our norms of practice.

Conclusion

To deny that important changes are on our doorstep would be suicidal for our profession. To acknowledge those changes but do nothing about it would show disinterestedness in the welfare of our patients and the profession.

We have thus chosen to recognize these changes, to pursue and understand their causes and effects and to map out a strategy for short term action in pursuit of long range goals of autonomy. We will come back to that subject the near future.

Claude Chikolne, D.D.S.
President

ACTUAL SITUATION:

- RAPID INCREASE IN THE NUMBER OF DENTISTS;
- GOVERNMENTAL INTERVENTIONS;
- DEVELOPMENT OF NEW MODES OF PRACTICE;
- PARTICIPATION OF INSURERS VIA DENTAL PRIVATE INSURANCE PLAN.

COMMON DENOMINATOR:

GREATER ACCESSIBILITY

AND

TRANSFERT OF THE RESPONSIBILITY OF DENTISTRY TO OTHER INTERVENING PARTIES (GOVERNMENT, CARRIERS,...)

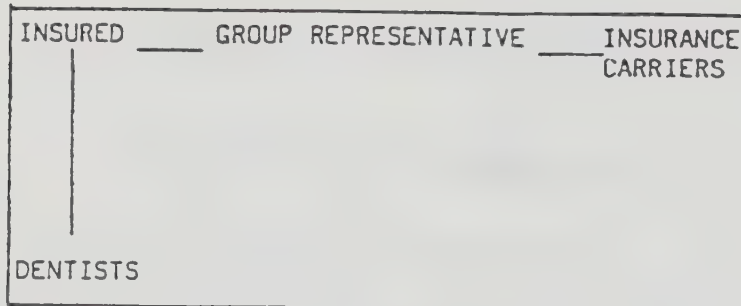
OBJECTIVES

TO CREATE A BETTER ACCESSIBILITY TO DENTAL CARE

AND

TO REGAIN AND CONSERVE THE CONTROL OF DENTISTRY TO DENTISTS AS A WHOLE.

FUNCTIONING OF ACTUAL
PRIVATE DENTAL CARE INSURED PLANS



1) NEGOTIATION BETWEEN THE EMPLOYER AND THE GROUP REPRESENTATIVE:

- TYPE OF REGIME
- REPARTITION OF THE PREMIUM

2) NEGOTIATION WITH INSURERS:

- SERVICE TO INSURED PEOPLE
- PREMIUM LEVEL

3) INSURED PERSON RECEIVES DENTAL TREATMENT

4) PAYMENT OF FEES

FIRST METHOD - MAJORITY OF DENTISTS:

- DENTIST RECEIVES PAYMENT DIRECTLY FROM HIS PATIENT
- INSATISFACTION FROM THE INSURED PATIENT:
 - i) MUST TEMPORARILY FINANCE
 - ii) THE AMOUNT RECEIVED FROM THE INSURANCE COMPANY MAY BE LESS THAN THE AMOUNT PAID
- PRESSURE ON THE DENTIST TO CONFORM HIMSELF TO THE INSURANCE PLAN

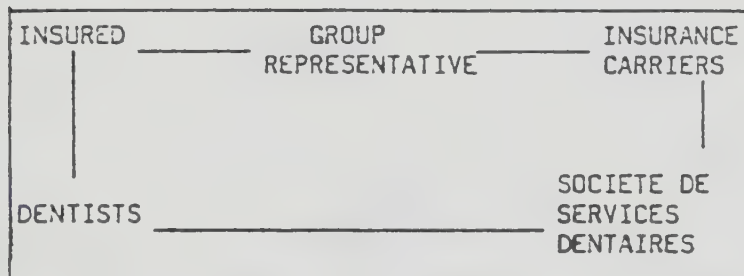
SECOND METHOD - MINORITY OF DENTISTS

- THE DENTIST CLAIMS HIS FEES DIRECTLY FROM THE INSURANCE CARRIER
- POSSIBILITY OF A PAYMENT INFERIOR TO HIS FEES - HE ACCEPTS OR BILLS THE PATIENT FOR THE DIFFERENCE
- PRESSURE ON THE DENTIST TO CONFORM HIMSELF TO THE INSURANCE PLAN.

5) CONCLUSION

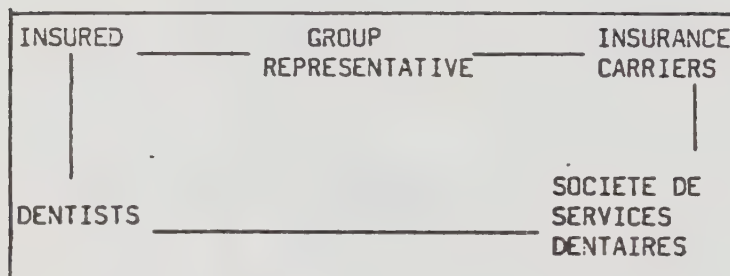
THE AGREEMENT BETWEEN THE INSURED PEOPLE AND THE CARRIER IS MADE WITHOUT THE PARTICIPATION OF DENTISTS BUT MAY INFLUENCE THEIR PRACTICE.

FUNCTIONING OF PRIVATE DENTAL
REGIMES WITH THE S.S.D.



- 1) IDEM
- 2) IDEM
- 3) IDEM
- 4) PAYMENT OF FEES TO THE DENTIST:
 - A) THE DENTIST RECEIVES PAYMENT DIRECTLY FROM THE S.S.D. FOR THE INSURED PORTION OF CARES
 - B) THE DENTIST RECEIVES PAYMENT FROM HIS PATIENT FOR THE NON-INSURED PORTION OF CARES
- 5) S.S.D. FINANCING:
 - A) CLAIMS:
 - THE CARRIERS WILL MAKE AVAILABLE TO THE S.S.D. THE AMOUNTS REQUIRED FOR THE PAYMENT OF CLAIMS.
 - B) ADMINISTRATION:
 - FROM THE CARRIERS: AMOUNT ALREADY PROVIDED FOR IN THE PREMIUM
 - FROM DENTISTS: WHEN IMPLEMENTING THE S.S.D.

AGREEMENT BETWEEN DENTISTS AND INSURERS
VIA LA SOCIÉTÉ DE SERVICES DENTAIRES



- 1) S.S.D. OWNED BY Q.D.S.A. AND CONTROLLED BY DENTISTS
- 2) ROLES OF THE S.S.D.:
 - A) ELABORATE DENTAL CARE PLANS
 - B) ADMINISTRATION OF CLAIMS
 - C) CONTROL THE APPLICATION OF THE PLANS
- 3) COMMITMENT OF PARTICIPATING INSURERS:
 - A) DELEGATE CLAIMS ADMINISTRATION TO THE S.S.D.
 - B) COMPLY INSURANCE PLANS TO THOSE ELABORATED BY THE S.S.D.
 - C) INSURED FEES IN CONFORMITY WITH THE Q.D.S.A. FEE SCHEDULE
- 4) COMMITMENT OF DENTISTS:
 - A) INSURED PORTION PAID DIRECTLY BY THE S.S.D.:
BETTER SERVICE TO THE INSURED PATIENTS
 - B) UTILIZATION OF USUAL TARIFF, BUT NO EXCESS BILLING FOR BASIC CARES.
- 5) COMMITMENT OF THE S.S.D.:
 - A) INSURERS:
 - MASSIVE PARTICIPATION OF DENTISTS
 - EFFICIENT SYSTEM OF ADMINISTRATION
 - COMMITTEE IN WHICH BOTH PARTIES (DENTISTS - INSURERS) ARE EQUALLY REPRESENTED
 - B) DENTISTS:
 - EFFICIENT SYSTEM OF ADMINISTRATION - RAPID PAYMENT TO THE DENTIST
 - COMMITTEE OF DENTISTS.

SUMMARY OF ACTUAL PRIVATE INSURED DENTAL PLANS

	<u>CATEGORY I</u> BASIC TREATMENTS	<u>CATEGORY II</u> COMPLEMENTARY TREATMENTS	<u>CATEGORY III</u> PROSTHODONTIA	<u>CATEGORY IV</u> ORTHODONTIA
DENTAL TREATMENTS COVERED	Prevention Diagnosis Fillings Extractions	Perio Endo .	Inlays Crown Fixed and Removable Prostheses	Orthodontia
DEDUCTIBLE	76% NO DEDUCTIBLE 241 PLANS: 24% \$25.00 to \$50.00 ANNUAL			
CO-INSURANCE	92%	85%	a) crown and inlays: 67% b) others: 57%	54%
MAXIMAL REIMBURSEMENT	For CATEGORIES I - II - III TOGETHER: \$500.00 or \$1,000.00 ANNUAL			\$1,000 to \$1,500 for Life

DEFINITIONS:

DEDUCTIBLE: ANNUAL AMOUNT PAID BY THE INSURED.

CO-INSURANCE: % OF DENTAL INSURED FEES THAT WILL BE PAID BY THE CARRIER. IT MAY VARY FROM 40% TO 100%

Dentaid

	<u>CATEGORY I</u> BASIC TREATMENTS	<u>CATEGORY II</u> COMPLEMENTARY TREATMENTS	<u>CATEGORY III</u> PROSTHODONTIA	<u>CATEGORY IV</u> ORTHODONTIA
DENTAL TREATMENTS COVERED	Diagnosis Prevention Emergency Fillings (A)	Endo Perio Surgery Fillings (A)	Gold foil Inlays Fixed and Removable Prostheses	Orthodontia
DEDUCTIBLE	NIL			
CO-INSURANCE	100%	100% or 80% or 50%	80% or 50%	50%
MAXIMAL REIMBURSEMENT	NIL	1,000 \$ ANNUAL		1,000 \$ LIFE

* Note: 100% means 100% paid by Dentaid, 0% paid by patient
80% means 80% paid by Dentaid, 20% paid by patient

(A): FOR THE FIRST YEARS OF THE SSD, WE MAY FIND FILLINGS IN EITHER CATEGORY I OR II BECAUSE OF SOME EXISTING PLANS. BUT ON SHORT TERM, FILLINGS MUST BE COVERED IN CATEGORY I ONLY.

ADMINISTRATIVE IMPLICATIONS IN A PRIVATE DENTAL OFFICE

SUMMARY DESCRIPTION OF THE DENTAL PLAN:

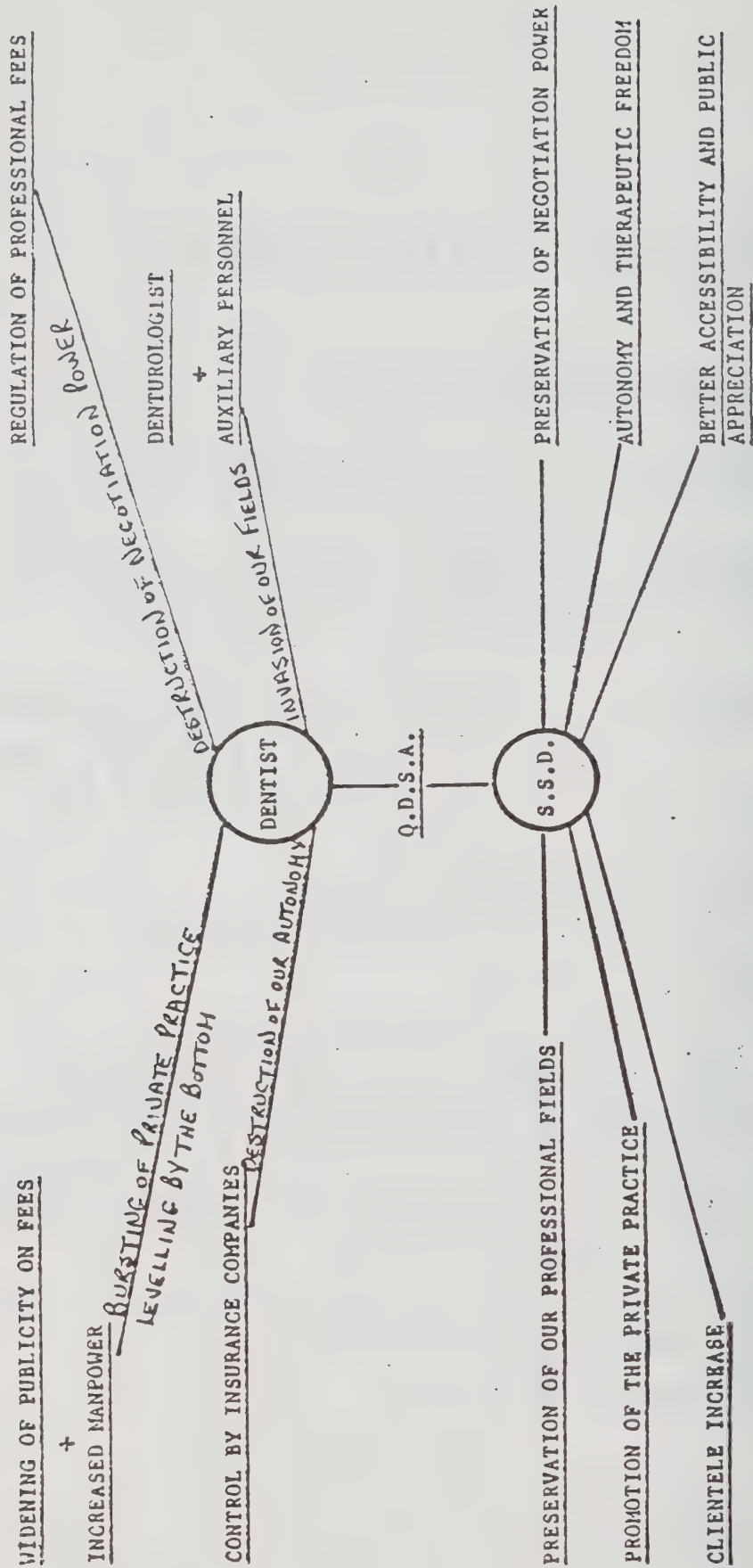
BASIC TREATMENTS: 100% COVERED - DENTIST USES HIS
CUSTOMARY FEES WITHOUT GOING OVER THE
INSURED TARIFF

OTHER TREATMENTS: COVERED UP TO 50%, 80%, 100% WITH AN
ANNUAL MAXIMUM OR A LIFETIME MAXIMUM
DEPENDING ON THE TYPE OF PLAN

FUNCTIONING

THE DENTIST MUST: KNOW IF HIS PATIENT
IS INSURED
KNOW THE NON-INSURED
PORTION OF HIS
PATIENT'S PLAN.

- 1) THE PATIENT PRESENTS HIS S.S.D. CARD
- 2) THE DENTIST DECIDES WHAT HIS TREATMENT PLAN WILL BE
- 3) PHONE CALL TO THE S.S.D.
 - A) IF THE TOTAL AMOUNT OF THE TREATMENT PLAN IS 300 \$ OR MORE: VALIDATION OF THE CARD AND PREDETERMINATION
 - B) IF THE TOTAL AMOUNT OF THE TREATMENT PLAN IS LESS THAN 300\$ AND INCLUDES BASIC TREATMENTS ONLY: VALIDATION OF THE CARD
 - C) IF THE TOTAL AMOUNT OF THE TREATMENT PLAN IS LESS THAN 300 \$ AND INCLUDES SERVICES OTHER THAN BASIC TREATMENTS: VALIDATION OF THE CARD, LISTING OF THE CODE NUMBERS AND USUAL CUSTOMARY FEES
- 4) WHEN THE TREATMENT PLAN OR A PART OF IT IS TERMINATED, THE DENTIST SENDS HIS CLAIM TO THE S.S.D.
- 5) RAPID PAYMENT BY THE S.S.D.



Service contract

APP. III

Between: La Société de Services Dentaires (A.C.D.Q.) Inc.
(hereinafter called "the SSD")
And The undersigned dentist
(hereinafter called "the dentist")

Whereas the SSD intends to encourage the implementation of dental insurance plans under which insured patients would not have to pay the dentist for the insured portion of the dental care;
Whereas the dentist wishes to take part in the implementation of these plans;

The parties hereby agree as follows:

- 1) The SSD shall draw up a list of dental insurance plans pursuant to this contract and shall provide the dentist with a copy of that list and of its alterations.
- 2) The SSD shall give the dentist rules of procedure so as to determine if the required dental care qualifies as an insured care.
- 3) The dentist agrees to follow this procedure and not to demand from the insured patient payment for the insured portion of the dental care.
- 4) In particular, the dentist hereby agrees as follows:
 - a) He shall send the claim for the insured portion of the dental care to the SSD within the fixed time as prescribed by the regulations of the SSD.
 - b) He shall accept the payment by the SSD as final, unless there is a possibility of having it reexamined by the competent committee provided for in the SSD's regulations.
 - c) The dentist recognizes that the SSD has the right to refer the claims he submitted, whether or not paid, to a peers' committee provided for in the SSD's regulations and agrees to accept the decision of that committee.
 - d) The dentist agrees to abide by the regulations made by the SSD and recognizes that failure to abide by those regulations or by this contract justifies the annulment of this contract by the SSD's board of directors, without reimbursement of the service fees paid to the date of said failure, and subject to an examination by the committee provided for in subparagraph c) of this paragraph.
- 5) The SSD agrees to pay for each claim within thirty days of its reception, unless in a case of absolute necessity or when a claim is regarded as contestable.
- 6) The dentist agrees to pay the following service fees:
 - a) for the four years counting from the date fixed by the SSD, according to paragraph 7 of this contract, a total sum of \$1000 payable within eight days of this contract;
 - b) variable fees withheld by the SSD, equivalent to a percentage of the claims, which percentage will be determined by the SSD's board of directors and must not exceed 2%.
- 7) This contract shall remain in effect for a period of four years from the date fixed by the SSD, following the drawing up of the first list provided for in paragraph 1 of this contract, and shall be renewed thereafter every three years, unless the dentist notifies the SSD in writing that he wishes to terminate this contract at least eighteen months before its expiration.
- 8) After the first four years of this contract, no fee other than the variable fees provided for in paragraph 6 b) can be demanded from the dentist, unless a decision to that effect is taken by the SSD's board of directors, which decision is approved by the majority of dentists using the SSD's dental services.
- 9) Notwithstanding the foregoing, the SSD may, at any time, terminate all service contracts entered into with the dentists, and in such event remit to them the unused portion of the service fees, as determined by the board of directors.

This text is a translation. For the sake of consistency, one must refer exclusively to the french text for any problem of interpretation.

Dated at _____
this _____ day of _____ 19____
Name _____ d.d.s./d.m.d.
(BLOCK LETTERS)
SSD per: _____ Dentist's signature _____

Contrat de service

Entre **La Société de Services Dentaires (A.C.D.Q.) Inc.**
(ci-après désignée comme la "S.S.D.");
et **Le dentiste soussigné**
(ci-après désigné comme le "dentiste")

Considérant que la S.S.D. entend favoriser la mise sur pied de plans d'assurance dentaire aux termes desquels les patients assurés n'auraient à effectuer aucun déboursé au dentiste pour la partie assurée des soins;
Considérant que le dentiste soussigné désire participer à la réalisation de cet objectif;

Les parties conviennent de ce qui suit:

- 1) La S.S.D. établira la liste des plans d'assurance dentaire visés par le présent contrat et fera parvenir au dentiste copie de cette liste et de ses modifications.
- 2) La S.S.D. transmettra au dentiste des directives quant à la procédure à suivre aux fins de vérifier si les soins requis sont des soins assurés.
- 3) Le dentiste s'engage à suivre ces directives et à ne pas exiger paiement du patient-assuré pour la partie assurée des soins.
- 4) Plus particulièrement, le dentiste convient de ce qui suit:
 - a) Il fera parvenir la réclamation pour la partie assurée des soins à la S.S.D. dans les délais que celle-ci déterminera par règlement;
 - b) Il acceptera le paiement de la S.S.D. comme final sauf quant à la possibilité d'une révision par le comité compétent prévu aux règlements de la S.S.D.
 - c) Il reconnaît le droit de la S.S.D. de référer l'étude des réclamations qu'il a soumises, qu'elles aient été acquittées ou non, à un comité de pairs prévu aux règlements de la S.S.D. et accepte de se soumettre à la décision de ce comité;
 - d) Il convient de respecter les règlements établis par la S.S.D. et reconnaît que le non-respect de ces règlements ou du présent contrat pourra justifier le conseil d'administration de la S.S.D., suite à une audition devant le comité prévu à l'alinéa c) du présent paragraphe, à annuler le présent contrat sans remboursement quant à tous frais de service acquitté à cette date.
- 5) La S.S.D. s'engage à effectuer le paiement de toute réclamation dans les trente jours de sa réception, sauf en cas de force majeure ou de réclamation jugée litigieuse.
- 6) Le dentiste s'engage à acquitter les frais de service suivants:
 - a) Pour les quatre (4) années à partir de la date fixée par la S.S.D. conformément au paragraphe 7 des présentes, une somme globale de 1000 \$, payable dans les 8 jours des présentes;
 - b) Des frais variables retenus par la S.S.D. correspondant à un pourcentage des réclamations, lequel sera déterminé par le conseil d'administration de la S.S.D. et ne pourra excéder 2%.
- 7) Le présent contrat demeurera en vigueur pendant quatre (4) ans à partir de la date fixée par la S.S.D., suite à l'établissement de la première liste prévue au paragraphe 1 de ce contrat et se renouvellera par la suite de trois (3) ans en trois (3) ans, à moins que le dentiste n'avise par écrit la S.S.D. de son intention d'y mettre fin au moins dix-huit (18) mois avant son expiration.
- 8) Après les quatre (4) premières années de ce contrat, aucun frais autre que les frais variables prévus à 6 b) ne pourra être exigé du dentiste à moins d'une décision du conseil d'administration de la S.S.D. ratifiée par une majorité des dentistes signataires du présent contrat de service.
- 9) Malgré ce qui précède, la S.S.D. pourra, en tout temps, mettre fin à l'ensemble des contrats de service conclus avec les dentistes en leur remettant la partie des frais de service non utilisée que le conseil d'administration déterminera, le cas échéant.

Daté à _____
ce _____ jour de _____ 19____
Nom: _____ *s.d.s./d.m.d.*
(EN LETTRES MOULÉES)
Pour la S.S.D. _____ Signature du dentiste _____

How to use it

The insured presents his **dentaide** card and health insurance card to prove his identity. A single phone call and the dentist receives confirmation of the patient's eligibility and of the expenses covered. As regards the treatment he is about to perform, he will be informed of which part of his fees is covered by the insurance plan and which part must be paid by his insured patient. The insured person pays only the expenses not covered by the plan.

The same applies to the insured dependents, except that they have to present the participant's **dentaide** card with their own health insurance card.

For more information

- on your dental care insurance plan, refer to the information material on the fringe benefits offered by your employer;
- on the Assurance-vie Desjardins **dentaide** card, contact your employer or your dentist, or Assurance-vie Desjardins at 1-800-463-4810, extension 2222.

If you are covered by an Assurance-vie Desjardins dental care plan, you may obtain a **dentaide** card. You will no longer have to pay the insured expenses and then submit a claim. You will only have to pay the expenses not covered by the plan.



Assurance-vie
Desjardins

dentaide

The **dentaide** card

• practical after the treatment
• easy to use



Assurance-vie
Desjardins

dentaide



**SIMPLE
PRACTICAL
UNIQUE**

You'll like it!

APP. IV



The Assurance-vie Desjardins **dentaide** card

The Assurance-vie Desjardins **dentaide** card is available to those covered by an Assurance-vie Desjardins dental care insurance plan.

It allows direct payment of insured expenses to the dentist. You no longer have to provide payment for those expenses and then submit a claim. You will only have to pay the expenses not covered by your plan.

The advantages of the **dentaide** card

Claim forms, as well as errors, become practically obsolete. You will know right away what expenses will be paid by the insurer and the amount you will have to pay yourself.

With this card, access to dental care is made easier, since you no longer have to provide full payment of dental care expenses and wait for a reimbursement. From now on, you will only have to pay the part of the expenses not covered by the insurance.

Use of the **dentaide** card is simple. *Without dentaide*, you have to pay the dentist, ask for receipts, complete a claim form and wait for the reimbursement of the insured expenses. In addition, you sometimes discover that some of those expenses are not insured. *With dentaide*, however, you pay the expenses not insured and that's all!

Who can use the **dentaide** card?

The Assurance-vie Desjardins **dentaide** card is available to all the participants of any group dental care insurance policy issued by Assurance-vie Desjardins, provided the policyholder requests it.

The card is used by the participant and by his dependents, if they are covered by the insurance.

Does it cost anything?

It is free and it reduces costs for the insured, who no longer has to pay the total cost of the treatments and wait for a reimbursement.

Also, **dentaide** will permit an effective control of benefits. The time and money saved and the increased effectiveness will help limit the increase of costs during the coming years.

TRANSLATION OF AN ARTICLE PUBLISHED IN THE
FEBRUARY ISSUE OF DENT POUR DENT

LET'S REMAIN PROFESSIONALS!

The dental profession as a whole is undergoing a complete transformation. We must once again point out that, for some time now, we have been concerned with the following methods for distributing dental care:

- dental nurse;
- dental therapist;
- denturologist;
- multi-duty auxiliary personnel;
- shopping centre or franchise dentistry.

Then, in view of our constantly rising fees, there was a reaction which oriented our thoughts to discussions on methods of remuneration:

- assignment;
- capitation;
- closed-panel;
- P.P.O. (Preferred Provider Organization);
- union clinic.

Faced with these problems, dentists, in all good faith, adopted certain policies which seemed to achieve the desired solutions, at least in the short term. But the dentist's heavy schedule, the increasingly numerous and demanding bureaucratic operations involved in dental practice, patient pressures, and more and more complex administrative procedures prevent him from weighing the impact of the decisions taken to deal with these new problems.

Today, therefore, we want to deal with the assignment issue. Because of the sheer size of this problem and the shattering consequences that it has for our entire profession, this article will serve as a follow-up to the communiqués being sent to all dentists in Quebec, whether or not they are Q.D.S.A. members.

To begin with, we will describe the assignment procedure and evaluate its impact. Then, we will weigh the advantages and disadvantages for the patients, the dentists, and the carriers. Finally, we will consider what can be done to counteract this scourge afflicting our profession.

(OVER)

The dentists opted for assignment in 1984 in order to find a better way to get themselves through the economic crisis. Patients have become accustomed to this idea of non-payment of fees, and they demand it today. In an effort to disguise their dependence, dentists chose this "solution" to alleviate the increasingly stiff competition resulting from the manpower surplus.

By informing the patient that he would accept the insured dental care plan, and by agreeing to be paid directly by the insurance company, the dentist thereby implied that he would treat the patient under the latter's insurance plan.

All the patient had to do was to sign the claim form, even before the treatment was given and the corresponding fees registered.

Since the fees agreed to by the insurance company depend on the premium paid and the treatments covered, the dentist must set up a very sophisticated data bank in order to avoid ending up in a deficit position. The dentist must know in advance the exact nature of the patient's insurance plan, which can vary considerably from one insured group to another.

As an example, for a given premium amount a patient could have 100% coverage for certain kinds of dental care, but based on a 1980 fee schedule. Another could have 80% coverage for a variety of dental treatments, based on the current year's fee schedule, and so on. The exact situation in each case depends upon the premium, the type of plan, and the insurer's claims experience.

By accepting assignment, the dentist agrees to accept payment of his fees by means of a cheque, the exact amount of which is known only to the insurer. In other words, the insurer is now in a position:

- based on premiums received (only the insurer knows),
 - based on the type of plan (only the insurer knows),
 - based on the claims experience of the plan (administered by the insurer),
- to control your fees.**

.../2

It sometimes happens that the cheque sent to the dentist will be equal to the fees charged. But it will be lower in the majority of cases, with two unwanted results. The first is simple, but costly: it is left up to the dentist to recover the unpaid balance. This causes misunderstandings which can often end up with the dentist losing a patient.

Several shrewd colleagues decided to get around this difficulty, thereby producing the second unwanted result. The dentist raises his fees, or bills for services which were not provided, as a way to be compensated for the lost fees. Without mincing words, this is fraud and constitutes a criminal offence.

The insurance companies are well aware of these procedures. They have established a practice profile for each dentist and are ready to take action against any offender.

Assignment not only has a harmful effect at the monetary level, it also leads you to abdicate your therapeutic freedom, to the benefit of the patient's insurance plan.

How can anyone understand this? How can we pardon someone who pretends to be a professional, yet at the same time will provide services not based on the patient's needs, but rather on the remuneration he will receive from the patient's insurance plan?

Following that realistic description of a situation which is steadily deteriorating, let's take a look at the advantages and disadvantages of assignment, as summed up in the table below:

	ADVANTAGES	DISADVANTAGES
a) <u>for the patient:</u>	- No paperwork - Fee burden lightened, or removed	- Demotivation - Loss of confidence - Premium increases
b) <u>for the dentist:</u>	- Marketing tool	- More complex administration - Loss of financial and professional autonomy - Loss of therapeutic freedom
c) <u>for the insurer:</u>	- Control of fees - Control of treatment plan	- Higher incidence of fraud

(OVER)

The main advantages for the patient are that paperwork is reduced to a minimum and the fee burden is lightened or, in some cases, removed completely. The patient does not need to wait for reimbursement from the insurance company, and in this way bears very little of the financial burden for the dental care received. The patient thus has the illusion that the dental care is a "gift from heaven".

The other side of the coin is that the patient completely ignores the value of the services rendered, and so appreciates them much less. Consequently, he has less interest in making sure that his treatment plan is followed to the letter and, as a result, can neglect the personal preventive programme which has been specifically designed to maintain or even improve his dental condition.

The patient ends up asking himself why he had to sign a blank form without knowing the amount of the fees which will be entered on it. If by chance he learns what the fees are, he then wonders whether the charges are higher than they would be if he didn't have insurance! The dentist-patient relationship, so vital for the success of our treatments, is disrupted by this doubt, which undermines the credibility of the profession as a whole.

Let's not delude ourselves any longer. People are talking that way, and this isn't the kind of reference that will help dental care insurance plans to multiply. In this scenario, costs are not coming down, neither are the insurance premiums...

The dentist, for his part, has the impression that by rendering a supplementary "service" he can use assignment as a marketing tool. He might in that way temporarily succeed in luring some patients away from his colleagues, whom he regards as competitors. But this is a very shortsighted view because, as all of us know, you never lose a good patient.

Considering what has just been demonstrated in this description of assignment, and in view of the stranglehold the insurers have on our financial independence and our right of therapeutic freedom in our practice, we must ask ourselves: is the game worth the candle?

Administrative procedures in the dentist's office are further complicated by the need to build up an entire system of information and considerations on each of the dental insurance plans in effect.

.../3

On top of all that, what can we say about the control of accounts receivable slipping into the insurer's hands? The insurer can, at any time, decide just when payment is to be made, or even delay it. Even in the case of assignment, certain insurers disregard the rules of fair play. So that their policyholders will know how much the dentist is paid, they issue the cheque in the name of the patient, who cashes it. The dentist must then chase the patient to receive payment.

Only the carrier can count on drawing some real advantages from the assignment procedure. But these advantages are short-lived at the best and far removed from the insurer's true role, which is to cover risks. No one can be criticized for wanting to control costs. But encouraging a method of remuneration which places an entire profession in a state of monetary and professional dependence is a far different matter. That can provoke a strong reaction, even our refusal to fill in all the details called for on the claim forms.

The first action we must take, as professionals, is to end the practice of assignment. To this end, you will soon receive an explanatory document which will prove useful to your patients. They are the ones we must think of, in the final analysis. We have to make them understand that such a procedure is contrary to their health and well-being, rather than place ourselves in a position of dependence on the insurers, who influence the market and even the development of dental treatment plans.

Let's remain professionals, and behave that way, even if that demands a lot. That is the only way to earn and maintain the respect of our fellow citizens.

IT'S UP TO US TO DECIDE!

Association
des chirurgiens dentistes
du Québec



**Translation of an article published in
the May issue of *Dent pour dent***

Methods of remuneration

U.C.R. (R & C) Program
(Usual - Customary - Reasonable)

Under this program, the insurer pays benefits in the form of fees to the dentist, but subject to a maximum. This ceiling is determined by the program administrator.

	Advantages	Disadvantages
a) for the patient:	— Flexible range of benefits available	— Plan is difficult to understand — Fee burden
b) for the dentist:	— Fee-for-service procedure protected	— Patient puts pressure on dentist to charge fees equivalent to insurer's payments — Pressure on dentist to accept assignment
c) for the insurer:	— Very large market — Control over fees, and sometimes treatment	— System is costly and difficult to administer

Note: In the United States, 73.3 % of dental services are insured under programs of this kind. (Source: A.D.A. — July 1985).

Schedule (Fixed Benefit or Table of Allowances Program (P.P.O.))

Under this program, benefits take the form of a set (discounted) amount established for each service covered. In return for agreement to accept discounted fees, the contractor will publish the names of contracting dentists and distribute them to members of the participating group.

	Advantages	Disadvantages
a) for the patient:	— Fee burden is decreased — Low premium	— Quality of dental care is affected
b) for the dentist:	— Fee-for-service — Possibility for increasing clientele	— Opens way to argument over fees — Pressure by patients for discounted fees — Fees controlled by third party
c) for the insurer:	— Publicity	

Note: A system of this kind is in effect in Quebec (Bromont). In the United States, 14.35 % of insurer dental services are covered in this way. (Source: A.D.A. — July 1985).

Comparison of Dentaide with other methods

U.C.R. (R & C)

Under this program, as with Dentaide, the principle of payment by fee-for-service is retained and the range of benefits can be very large.

With Dentaide, by contrast, there are no ceilings on the fees that can be charged and, despite the advantages this plan offers, it costs no more to join than any other conventional program. Furthermore, Dentaide lets the patient know immediately the exact amount not covered by the plan that he will have to pay, if such a situation should arise. Finally, the patient will pay nothing for dental work covered by the basic plan, nor will he have to send any request for payment to the insurer through his employer or union. Thus, Dentaide is clearly superior to the U.C.R. (R & C) Program.

Schedule (Fixed Benefit or Table of Allowances Program (P.P.O.))

Dentaide reduces the fee burden to an even greater extent than the P.P.O. program does, while offering the same advantages to the patient, the dentist and the insurer.

In addition, Dentaide directly counters all the P.P.O. disadvantages, making this S.S.D. alternative much more valuable to the dentist.

Freedom belongs to those who se

Introduction

It must be acknowledged at the outset that the business aspect of dentistry has become more prominent during the past ten years than in any previous period. Dentistry has been going through a period of turbulence and great uncertainty in terms of market trends. Dental care supply and demand have been significantly affected by such factors as: the too rapid increase in manpower, the growth of private dental insurance, governmental hesitations in the area of public dental care plans; the laxity of certain colleagues with regard to advertising;

repeated attempts by the parodontal sector to move into our field of activities, the constant harassment of the Quebec Professions Board, and the appearance of other methods of distribution and reimbursement such as shopping centre clinics, P.P.O., capitation, union clinic etc. These factors (in association with consumer movements, the economic uncertainty in the context of the rationalization of costs and the public perception of dental care fees and the overall behaviour of our profession) contribute to the destabilization of our professional environment.

Capitation

This is a system under which the contracting dentist is reimbursed on the basis of a fixed, per capita fee. Payments are usually made monthly, and are based on the number of persons in the program and the duration of the insured party's contract, whether or not the services are used. Under this system, the dentist assumes the financial risk and the insured is eligible for treatment under his plan only if he requires the services of a participating dentist who is assigned to him for a 12-month period.

	Advantages	Disadvantages
a) for the patient:	— Fee burden is almost eliminated — Limited amount of paperwork	— Cannot choose own dentist — Treatments subject to set fee per client
b) for the dentist:	— Cash flow is stabilized — Less work done on credit — Administrative costs decreased — Greater number of potential patients	— Cannot choose own patients — Assumes financial risks — Insurer has clinical and administrative control — Accounting system is changed — Fees are set unilaterally by insurer
c) for the insurer:	— Control over dental care providers — Control over costs — No financial risk	

Notes: Capitation is now in effect in Ontario, while dentists in Nova Scotia, as well as Alberta, are worried that it will appear there. In the United States, 3.18 % of individuals in private dental care insurance plans are part of such a system. (Source: A.D.A. — July 1985).

Direct Reimbursement Program (Self-directed Plan)

Under this program, a large employer or a substantial number of employees pay a certain amount per individual into a dental fund, instead of dealing directly with an insurance company.

The most typical program can be described this way: the employee in the plan visits a dentist of his choice, pays the dentist's fees and submits the receipt to his employer, who reimburses him directly from the fund set up for that purpose.

The employer can direct the plan himself, or have it administered externally.

	Advantages	Disadvantages
a) for the patient:	— Plan is easy to understand — Can choose his own dentist — No paperwork	— Substantial initial fee burden, before reimbursement — Restricted range of benefits
b) for the dentist:	— Freedom to choose his own patients — Able to retain his independence	
c) for the employer:	— Additional ammunition for his negotiating arsenal	— High financial risk

Notes: Plans of this type are already in effect in Quebec. In the United States, they represent only 0.51 % of individuals covered under private dental insurance plans. The A.D.A. supports this program.

Société de Services Dentaires (A.C.D.Q.) Inc.

The S.S.D. is a company set up to administer claims for dental care. It was established by Quebec's dentists to preserve their professional independence, while encouraging greater accessibility to dental care by creation of the DENTAIDE card.

	Advantages	Disadvantages
a) for the patient:	— Reduces fee burden — Eliminates paperwork — Gives information on care provided — Provides immediate knowledge of financial responsibilities	

	Advantages	Disadvantages
b) for the dentist:	— Increases clientele — Facilitates administration — Complete independence — Clarifies situation for dealing with financial arrangements	— Controlling use of card

Capitation

At first glance, the fee burden reduction seems more important under this program than with Dentaide. This is largely compensated for with Dentaide, however, because the services provided under our plan are based on the patient's needs and not on a per capita assessment.

Under the Dentaide system, the dentist does not assume the plan's financial risk, while benefiting from all the advantages provided by the per capita assessment program.

Direct reimbursement

We know that this is the system that the American Dental Association prefers over other methods of remuneration advanced by the insurer. Dentaide offers all the same advantages as this system does, without any of the inconveniences for patient, dentist or insurer.

Freedom belongs to those who seek and win it. Freed profession is seeking, and that is what Dentaide offer

k and win it

The profession has never hauled on the carpet so much, and so often. Even though we have a right to feel that we are under attack, we must react calmly, analyze the causes, and take the situation firmly in hand so that we can adapt to the changes while proving we are imaginative enough to come up with alternative solutions.

So, let us first examine the different methods of remuneration which are springing up around us with the aim of controlling our fees. We will define each of these methods which now exist, so as to show the advantages and disadvantages in each case. Finally, we will compare all those methods with Dentaide.

Service Benefit Program

This concept, which is the main trademark of the Delta Dental Plan, Blue Cross, and Blue Shield, offers the insured benefits which are based more on services than on costs. Under this program, the dentist agrees that the insurer will publicize his services, in return for accepting the fees set by the insurer. Example: the insurer requires the dentist to submit his list of fees for a complete examination, including X-rays and scaling; the dentist agrees to allow the insurer to verify those fees by examining the dentist's files.

Once this has been done the insurer establishes an average, which is usually slightly lower than the dentist's regular fees, and imposes a "package fee" on the dentist for this series of procedures. Example: \$30 for the first visit, including complete examination, X-rays and scaling; and \$15 for periodic visits thereafter, which you can be sure also include all the above-mentioned services. The insurer also determines the frequency of visits. Furthermore, the dentist is paid directly by the insurer and cannot charge the patient any additional amount.

	Advantages	Disadvantages
a) for the patient:	— Fee burden is reduced — Large range of services	— Frequency of visits determined by the insurer
b) for the dentist:	— Publicity	— Opens way to arguments over fees — Loss of independence
c) for the insurer:	— Direct control over the dental profession	

	Advantages	Disadvantages
c) for the insurer:	— Lower administrative costs — Possibility for offering improved product — Collaboration with dental profession	

Union Clinic

This program is based on the hiring of a salaried dentist who provides dental care for a given group of employees exclusively, or almost exclusively.

	Advantages	Disadvantages
a) for the patient:	— No fee burden — Very large range of services	— Cannot choose own dentist
b) for the dentist:		— Cannot choose own patients — Loss of clientele — Competition with private office
c) for the employer:	— Control over costs	

Note: British Columbia and Ontario are the primary targets of this type of problem. In Manitoba, the unions have conducted a survey among dentists regarding their fee schedule.

Service Benefit Program

Dentaide offers both dentist and patient the same advantages as this system does. But, in contrast to S.B.P., Dentaide lets the insurers play their proper roles — which is to assume the risks — and leaves it up to the organizations which have given it the specific mandate, to exercise the controls required by the profession.

In addition, Dentaide has none of the disadvantages of S.B.P.

Is what our
profession.

Union Clinic

It is difficult to compare a program where the dentists are on salary with one based on fees for services. Nevertheless, the Union Clinic system disadvantages are not found in the Dentaide plan. Due to its basic structure, Dentaide is flexible enough to administer the self-insured plans and permit the unions to avoid large investments in equipment and salaries they would otherwise need. But, we must add that it has not yet been proven that the union members will easily agree to the imposition of a dentist. Therefore, Dentaide is an eminently valid alternative to this solution proposed by the union.

Assignment

This method of payment, if we can call it that, can best be defined as the state of dependence on the insurance companies in which the dentists have placed themselves.

With assignment, the patient doesn't know the nature of the dental care provided, or the amount of the fees charged by the dentist. In this context, the dentist agrees to be paid by a third party, based on the terms of a contract and a fee schedule of which he is unaware.

	Advantages	Disadvantages
a) for the patient:	— No paperwork — Fee burden is removed	— Demotivation — Loss of confidence — Higher premiums
b) for the dentist:	— Provides a marketing tool	— More complex administration — Loss of financial and professional independence — Loss of therapeutic freedom
c) for the insurer:	— Control over fees — Control over treatment plans	— Higher incidence of fraud

Assignment

Under this system, the patient is unaware of the exact nature of the dental work provided and the fees claimed by the dentist from the insurance company.

The dentist, by accepting the patient's demand for assignment, agrees in advance to be remunerated according to fees and rules of application which are unknown to him, and from which he has no resort. In the event of litigation, the dentist is placed squarely in a dependent situation, and will find it very difficult to win the case. In other words, the dentist gives the insurer a mandate to control his dental fees, and it is only a small step from that to a point where his practice is being controlled. For the insurer, assignment means that the dental profession is submitting without a fight.

This payment method engenders an ever higher rate of fraud because the dentists try to neutralize their losses of fee revenues. The insurer seeks protection against fraud loss by building up practice profiles that allow them to make an already submissive profession even more docile.

Thus, Dentaide has no relationship whatever to assignment. Quite to the contrary: with Dentaide the patient knows the nature and cost of the dental care provided, as well as his financial obligations. This immediately eliminates the fraudulent practices encountered in the assignment system. But the most important thing is that the patient, knowing the nature of the work being done, is more interested and motivated to maintain a high level of dental health and avoids being talked into any supplementary work. The patient rapidly learns that the need for out-of-pocket costs disappears when he receives only basic care.

Under the Dentaide system, each situation is clearly spelled out. The dentist avoids needless discussions and the patient develops confidence in his dentist, while appreciating the value of his dental insurance plan. This confidence changes to admiration when the patient learns that he can thank his dentist and the dentist's colleagues for being able to reap even more advantages from his dental insurance plan.

The major shortcomings in the assignment system arise not just from the fact that fees are paid by a third party instead of the patient, but rather because of the state of dependence on the insurer in which the dentist is placed. Such a situation does not occur with Dentaide, where the patient, the insurer and the profession all maintain their complete and entire independence.

*Association
des chirurgiens dentistes
du Québec*



COMMUNIQUE NO. 146

Subject: LET'S PUT AN END TO ASSIGNMENT!

Dear Colleague:

The dentist-patient relationship is a two-way street. On the one hand, you have the responsibility for seeking ways to obtain and maintain an optimal degree of dental health for your patient. On the other hand, it is your patient's duty to respond to your professional efforts by putting your advice into practice. Moreover, in addition to this personal motivation, your patient has monetary obligations to meet with regard to the services he received.

Assignment compromises the dentist-patient equilibrium. This is an important problem which we must get rid of before it becomes permanently rooted in our profession.

In order to ensure that your patient is in a position to appreciate the true value of your services, you must inform him or her of the amount of your fees, while being flexible enough to suggest solutions that will help them meet their obligations.

Why do patients ask you for assignment?

In this way, patients try to avoid having to pay your fees immediately, by shifting one of their primary responsibilities to a third party.

What a patient is actually saying when he asks you for assignment is: "Must I pay you right away?"

We know that the great majority of people regard dental care as a luxury, and therefore as a too onerous expense. People have got out of the habit of paying for dental care. Even though dental health is a vital factor in maintaining good overall health, it will not be easy for you to reverse this trend.

(OVER)

What should your attitude be?

If you give a categorical "No" answer to the "Do you accept assignment?" question, your patient will most likely go to another dentist.

So, you must handle the situation properly to avoid the risk of losing a patient because you have not taken the time to give this question the attention it deserves.

Remember the advice in our marketing inserts: you must talk frankly to your patients, especially about fees. Anyone who has come to you for dental services has confidence in you, obviously. A frank and open discussion will not only help you to preserve this confidence, but will at the same time increase your clientele.

Remember these basic rules when you discuss fees: be brief, straightforward and flexible when offering your patient solutions both for carrying out the treatment plan and how to pay for it.

In order to help you make the right approach to your patients, we are enclosing a durable, plastic-coated "prompter board" that provides you with two discussion scenarios, by means of typical questions and answers.

Talk to your staff about them, and explain how they can help save a great deal of time.

It is also very important to make your receptionist well aware of the dangers of assignment. A good understanding of the problem will make her much more convincing. This conviction will be reflected in her discussion with the patient, making it easier for the patient to accept the validity of the solutions offered.

The initial discussion and the way you approach the problem are of primary importance, because you might not get a second chance.

.../2

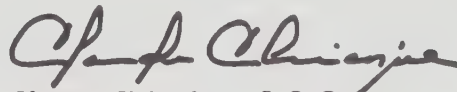
Your patient must recognize the validity of your approach, right from the beginning. Don't hesitate to tell him or her that assignment means increased costs for insurers, who then palm them off on the policyholders by increasing their premiums.

Whenever a patient, whether a new or old one, calls up your office and asks: "Do you accept insurance?", your receptionist must be able to say: "We can offer you something even better; talk to us about it on your next visit".

The esteem enjoyed by a profession is measured in large part by the constant efforts of its members, both in words and actions, to earn and deserve a reputation for providing true value in the services it renders.

For our patients' well-being and for the survival of our own autonomy, we must all remember every day, each in our own office, to pursue this common goal: Let's put an end to assignment.

Professionally yours,

A handwritten signature in dark ink, appearing to read "Claude Chicoine". The signature is fluid and cursive, with the first name "Claude" and last name "Chicoine" clearly distinguishable.

Claude Chicoine, D.D.S.
President

CC/sd
April 2, 1986

DENTAL SERVICE AGREEMENT

APPENDIX IV

THIS AGREEMENT entered into this _____ day of _____, 19____

BETWEEN:

FUTURE FOCUS HEALTH SYSTEMS LTD., a corporation duly incorporated under the laws of Canada,
(hereinafter referred to as "Future")

OF THE FIRST PART;

— and —

(hereinafter individually referred to as a "Dentist" and collectively referred to as "Dentists")

OF THE SECOND PART.

WHEREAS Future has established a dental health care service plan (the "Plan") to provide prepaid dental care to eligible subscribers and their dependents, if applicable;

AND WHEREAS Future wishes to retain the Dentists to provide services to those persons eligible to receive same;

NOW THEREFORE THIS AGREEMENT WITNESSETH that in consideration of the mutual covenants and premises herein contained, the parties hereto agree as follows:

1. The parties acknowledge and agree that the foregoing recitals are true in substance and in fact.
2. During the term of this agreement, including any extension or renewal thereof, the Dentists shall render dental care to eligible subscribers and dependents under the Plan (hereinafter referred to as "Eligibles"), in accordance with the covered dental services, exclusions, limitations, supplemental fees or charges and other provisions relative thereto, as set out in any schedule attached.)
3. The Dentists acknowledge that the dental services shall be performed at the following addresses, unless otherwise specifically agreed to in writing between Future and the Dentists:
 4. Future will offer the Dentists the opportunity of providing the services under a negotiated Plan under the following conditions:
 - (a) A copy of all proposed plans for which the Dentists can provide services shall be forwarded to the Dentists. The copy shall include services to be performed, per capitation fee, supplemental fees due, and any other information pertinent to the delivery of care. If Future does not receive a notice to the contrary within fifteen (15) days of mailing the plan, Future shall assume that Dentists agree to provide care under the plan and will list Dentists as providers for that particular plan. The Dentists shall make no other charge or request for payment from Eligibles or Future other than as set out in this Agreement together with attachments.
 5. (a) As full and complete compensation for all dental health care services to be performed by the Dentists under a particular plan (exclusive of supplemental charges and charges for non-covered services), Future shall pay to the Dentists such capitation fees as are set out in any negotiated plan forming part of this agreement;
 - (b) Payment under any negotiated plan which forms part of this agreement shall be remitted to the Dentists with respect to each Eligible, within fifteen (15) days of the receipt of capitation fees from the payor company and/or union. The Dentists hereby designate _____ as their duly authorized agent to receive said payments on their behalf and payment by Future to said agent shall be sufficient to relieve Future of any further obligation to the Dentists with respect thereto.
 6. This agreement shall become effective, in respect of any particular negotiated plan, on the starting date of each such negotiated plan, as attached hereto, and shall remain in effect for an initial period of three (3) years. Said agreement shall, with respect to such plan, thereafter be automatically renewed for successive thirty-six (36) month periods unless terminated by either party by giving written notice of such termination to the other party at least three (3) months prior to the termination of that particular plan. Furthermore, either party may terminate this agreement at any time, upon giving three (3) months' notice.
 7. The Dentists shall have no obligation to any Eligible on or after effective date of the termination of eligibility or termination of this agreement, except that the Dentists agree to complete any work in progress in respect of a specific dental procedure commenced prior to, but incomplete on, said termination date. Future shall continue to be responsible for monthly per capitation fees as set out in this agreement until such specific procedure is completed.
 8. Unless the Dentists receive the payment within three (3) weeks from the date of providing written notice to Future that an Eligible has not made payment for chargeable treatment, the Dentists shall have the right to discontinue treatment of an Eligible in the event said Eligible does not make payment for chargeable treatment in accordance with the terms of Schedule "A", or another plan attached as a schedule to this agreement.

9 The Dentists shall maintain a 24-hour telephone service to handle emergency calls from Eligibles, and it shall be the Dentists who determine whether a particular call is an emergency.

10 The Dentists must be capable of scheduling appointments within fifteen (15) working days for routine examination, rec and preventive therapy, and must render emergency treatment within twenty-four (24) hours. The Dentists shall determine the professional care required by each Eligible and shall have the duty to perform such care pursuant to the usual and customary standards of the community.

11 Future may appointment one or more dental consultants to conduct periodic reviews and evaluations of the Dentists' facilities and standards of care. The Dentists shall co-operate in all respects with the dental consultants and shall accord them reasonable access to the Dentists' records and offices in order for them to perform such evaluations.

12 During the term of this Agreement, the Dentists shall make every reasonable effort to maintain adequate staff, personnel, laboratory facilities and equipment to enable them to properly perform the required services hereunder. In case of catastrophe, with loss of one of the office premises, a reasonable length of time will be given to the Dentists to reassign patients to other office premises and to deliver care to Eligibles.

13 The Dentists shall notify Future of the names of Eligibles who have habitually broken appointments or who have habitually behaved in a grossly discourteous manner toward the Dentists, their employees, or other patients. Future will, immediately upon notification, investigate the complaint and provide the Dentists with the results of the investigation.

14 The Dentists shall as soon as reasonably appropriate notify Future in the event of any controversy concerning the quality, necessity or desirability of any dental service or procedure contemplated or performed.

15 Future shall furnish the Dentists, on a monthly basis, with a list of persons (including individual subscribers and covered dependents) entitled to receive dental care from the Dentists pursuant to the Plan. A person shall cease to be eligible when a written statement to that effect is supplied to the Dentists by Future or when such persons named shall not be included in the most recent list of Eligibles supplied by Future to the Dentists. The Dentists shall be entitled to rely upon the accuracy of the most recent list of Eligibles furnished to them by Future.

16 It is expressly understood that in the event that Future is at any time indebted to the Dentists for any compensation or other monies due or is otherwise in default under this agreement, subject to the terms of this agreement, the Dentists shall only be required to provide emergency services to Eligibles and complete any specific work in progress in respect of a specific dental procedure commenced prior to, but incomplete at, the time of default.

17. (a) The Dentists agree to save harmless, defend and indemnify Future and the officers, trustees and agents thereof, from and against all claims, demands, causes of action, liability and damages (including reasonable attorney's fees) that may arise

(i) out of any alleged malpractice or negligence caused or alleged to have been caused by the Dentists, their staff, their agents or employees in the performance of, or omission of, any duty assumed by the Dentists hereunder or in connection therewith. The Dentists agree to maintain a policy of insurance for this purpose with a responsible licensed insurance company and to obtain an appropriate endorsement for the benefit of Future and its officers, directors and agents; said policy to provide coverage in an amount not less than Five Hundred Thousand (\$500,000.00) Dollars for injury to or death of any one person, and in an amount of not less than One Million (\$1,000,000.00) Dollars for injury to, or death of, more than one person in any one year during the existence of this agreement;

(ii) by reason of the exercise of the rights and duties granted or conferred hereby, or the operation of the Plan, including, but without being limited to, all claims, demands, causes of action, liability and damages arising out of or alleged to arise out of, the condition or alleged condition of the premises used in the conduct of the Plan or the installation, use, maintenance, operation, repair or removal of the dental furniture, furnishings, fixtures, or equipment, whether sustained by the Dentists or Future, their respective agents or employees, or by any other persons, firms, or corporations which seek or may seek to hold Future and/or any of its officers, directors or agents liable therefor, provided that any such claim is not due to negligence by Future and/or any of its officers, directors, agents or servants, or otherwise. The Dentists agree to maintain a policy of insurance for this purpose with a responsible licensed insurance company and to obtain an appropriate endorsement for the benefit of Future, its officers, directors and agents, said policy to be in an amount not less than Five Hundred Thousand (\$500,000.00) Dollars for injury to or death of, any one person, and in an amount not less than One Million (\$1,000,000.00) Dollars for injury to or death of, more than one person in any one year during the existence of this agreement, and in an amount of, or resulting from, any single accident, occurrence or transaction;

(b) Future may require the Dentists to provide evidence of this coverage at any time during the term of this agreement.

18. The Dentists shall maintain complete and up-to-date records in accordance with accepted professional standards, sound dental procedures and internal control practices, which records shall reflect the date each eligible was seen, the procedures followed, the name, address, and specialty of each specialist or other dentist to whom such patient was referred. Such records shall be made available for inspection by Future or the dental consultants during regular business hours and other reasonable times. Future or its dental consultants shall from time to time provide forms for keeping certain records, which forms Future shall require to be submitted to it on a periodic basis. Future or its dental consultants may establish the form in which records are to be submitted so that they are compatible with existing data collection and data processing procedures.

19. (a) Future may cause a grievance committee to be formed consisting of equal representation from the Dentists and Future. Disputes between the parties to this agreement concerning performance or interpretation of this agreement or the relationship of Future and the Dentists hereunder may be submitted to the grievance committee which shall hear the dispute and recommend a resolution. Such recommendation shall not bind either party; however, submission of a dispute to such grievance committee and reasonable consideration of its timely recommendation shall be a condition precedent to either party seeking to resolve a dispute by arbitration.

(b) If any dispute occurs among the parties hereto with respect to any matter which cannot be resolved by the provisions hereof or by agreement of the parties, the matter in dispute shall be resolved by arbitration. Any party to the dispute may at

any time require arbitration by giving written notice thereof to the other party. The dispute shall be determined by a single arbitrator if the parties can agree upon one within ten (10) days from the receipt of the notice, failing which an arbitrator shall be appointed by the Senior Judge of the County Court of the Judicial District in which Dentist practices, upon the application of any of the parties and the Senior Judge shall be entitled to act as such arbitrator if he so desires. The arbitration shall proceed in accordance with the provisions of the Arbitrations Act of the Province in which Dentist practices. The decision arrived at by the Board of Arbitration, however constituted, shall be final and binding and no appeal shall lie therefrom.

20. The Dentists are engaged and retained by Future only for the purpose and extent set forth in this agreement and the relationship of each Dentist to Future shall be that of independent practitioners engaged and retained to perform professional services, without any control by Future as to the manner or means of performing his professional services, subject to the terms of this agreement.

21. (a) In the event that a Dentist shall become legally disqualified to practice dentistry and such disqualification is not subject to appeal, or is not in fact appealed by the Dentist, Future may notify each Dentist that the Dentist who is no longer qualified to practice dentistry will immediately cease to be a party of this agreement, and have no further rights or obligations hereunder. In the event that a Dentist is reinstated and permitted to practice dentistry, he may, upon providing written notice to Future be reinstated as a party to this agreement and shall subsequently be entitled to all rights and subject to all obligations hereunder.

(b) In the event that a Dentist breaches any term of this agreement, Future shall notify such Dentist, setting forth the particulars of such breach, and the Dentist shall have thirty (30) days to cure such breach. If the Dentist fails to cure such breach within the aforesaid thirty (30) days, Future may notify the Dentists that such defaulting Dentist will cease to be a party to this agreement and shall have no further rights or obligations hereunder.

22. In the event that Future fails to make a payment due hereunder within thirty (30) days at the due date of such payment, the Dentists may notify Future in writing of such failure to pay. In the event that payment is not made by Future within fifteen (15) days of the date on which Future is deemed to have received notice of such default, the Dentists may terminate this agreement subject to any requirement to complete services as set out in this agreement.

23. In the event that Future institutes, or consents to the institution of bankruptcy proceedings, or is adjudicated bankrupt, then this agreement may be terminated by the Dentists upon thirty (30) days notice, provided that the Dentists shall be required to complete any specific work in progress in respect of a specific dental procedure commenced prior to, but incomplete at, the date of termination.

24. It is agreed that the Dentists' rights, duties and interests hereunder may not be assigned or delegated in whole or in part without prior written consent of Future, except that such services may be performed by associates of the Dentists.

25. The Dentists acknowledge and agree that they will cause any dentists associated with them in the practice of dentistry to comply with the terms of this agreement. Each Dentist who signs this agreement shall be responsible jointly and severally for any associate dentist working for them under the terms of this agreement.

26. All notices required or deemed necessary hereunder shall be in writing and shall be served either by delivery in person to any signatory hereof or by prepaid registered mail, which notices shall be given at the following addresses:

(a) To Future at:

1320 Yonge St.
Toronto, Ontario M4T 1X4

(b) To each of the Dentists at:

provided that any parties hereto may change such address by giving notice of change to the other parties in writing. Any notice, if delivered, shall be deemed to have been given on the date on which it was delivered, and if sent by prepaid registered mail, shall be deemed to have been given on the second (2nd) business day following the date of mailing.

27. It is agreed that the rights, duties and interests hereunder of any party may not be assigned in whole or in part without the prior written consent of the other party, except that any of the Dentists may assign their interests hereunder to a corporation of which they and/or members of their family are the sole beneficial shareholders, providing that they are legally entitled to do so. Except as hereinbefore set out, Future shall negotiate only with the duly licensed dentists listed in this agreement regarding the delivery of dental care or contractual obligations under any negotiated plans. Payment of capitation fees will be made as per paragraph 5(b) and Future will not determine benefits due to any individual dentist. In the event Future is made a party to litigation by any heirs, executors, administrators, successors or assigns of any of the dentists, the Dentists agree to defend and hold Future harmless from any loss including reasonable attorney fees in connection therewith.

28. No amendments may be made to this agreement unless they are made in writing and signed by all of the parties hereto, but the parties recognize that certain changes may be required to comply with the Royal College of Dental Surgeons.

During the term of this agreement and for a period of one (1) year following its termination, the Dentists agree they shall not directly or indirectly engage in the rendition of dental services to any subscriber group previously serviced through its association, Future, provided that this restrictive covenant shall have no application whatsoever if this agreement is terminated by Future as a result of the failure by Future to pay any amount due to the Dentists.

IN WITNESS WHEREOF the parties hereto have executed this agreement on the date and year first above written.

In The Presence Of:

FUTURE FOCUS HEALTH SYSTEMS LTD.

per:

INTRODUCTORY NOTES TO THE 1987 BUDGET

The following notes are intended to facilitate your review of the 1987 CDA Budget.

General

The 1987 Budget is forecast on developed activity plans, an analysis of the 1985 Financial Statements, the current year's interim financial statements, and the experience of the staff members in managing the programs.

Presentation

The budget is being presented in a format somewhat different from last year. A notable change is in the presentation of expenses, which have been summarized by project area. This presentation is intended to provide you a better understanding of the true cost of each project or council/committee area.

The front page of both the revenue and expense budgets is a summary of the attached pages.

Functional Accounting

We have continued to move in the direction of functional accounting. In full functional accounting, each department is allocated an appropriate portion of their overhead expenses. In this budget, we have so allocated staff payroll, temporary staff, and staff benefits. As a result, you will notice what appears to be a substantial increase in the line item "staff" in each department. As well, you will see a corresponding reduction in the administration budget. This may be somewhat confusing but it should only be a short-term problem. In future years the budget presentation should be easier to understand.

"ERR" Messages

In reviewing the budget, you will notice under the "1987 Budget/1986 Budget" column, several instances where the letters ERR appear. This is an indication by the computer, that an error has been made. In fact, an error has not been made. This message occurs where there is an item in the '87 budget column without a corresponding item in the '86 budget column. Hence, a number divided by zero. While mathematically an error, it was left in intentionally to show the change from one year to the next.

Meeting Costs

To simplify the calculation of Council and Committee meeting expense, a formula was used encompassing the scheduled number of meetings, the duration of those meetings in days, and the number of participating members. Cost factors of \$500 for return airfare and \$195 per night for accommodation and meals were also plugged into the formula. Using this formula, we projected the cost of the various meetings. Subsequently, staff reviewed these costs, and based on their experience, adjusted them up or down.

Some specific items require further explanation. On the summary page of both the revenue and expense budgets, down the far right-hand column, are line numbers. The following notes refer to the items by number.

Revenue Budget Notes

Note 1 - Line 1

Membership fee revenue, from Active members, has been projected by taking the number of members used to calculate the 1986 budget figure and multiplying that number by the 1987 membership fee of \$260. The '87 budget does not reflect any growth in the number of members experienced in 1986, nor does it include a projected increase in members for 1987.

Note 2 - Line 2

Corporate fee revenue includes the increase in the corporate fee from \$8 to \$10. Again, the '87 budget is based on the number of members in the '86 budget.

Note 3 - Line 5

Student fee revenue is based on a fee of \$16.

Note 4 - Line 9

The Grants-Transfers of Corporate Fee item is the funds from the corporate bodies used in the area of accreditation. It reflects an increase in these fees from \$5 to \$10.

Note 5 - Line 14

National Dental Health Month revenue is monies received through the sale of such items as pins and buttons.

Note 6 - Line 16

We anticipate continued growth in the sales of pamphlets.

Note 7 - Line 17

The convention is shown in revenue, net of expenses. The 1987 convention will be held in conjunction with the QDSA and consequently only \$5,000 has been included in the '87 budget to cover the cost of staff attendance.

Note 8 - Line 19

The Journal advertising revenue is based on full circulation.

Expense Budget Notes

Note 1 - Lines 1, 22, 30, 39 and 48.

As mentioned, the staff line item in each department on the expense budget reflects a move towards functional accounting. Included in this item are staff payroll, benefits, temporary staff, miscellaneous expenses, and staff travel and accommodation expense. The line item consequently shows a significant increase in the '87 budget over the '86 budget. Also a consequence of this change, the administration budget is correspondingly lower. The '86 budget was not broken out in this manner.

Further, as one can see from the breakout pages, a 10 percent increase in payroll was budgeted to cover cost of living adjustments (COLA), merit increases and possible new staff. Other items, for example staff benefits, are projected based on experience. Line 22 reflects the fact that staff benefits have been transferred out of administration and into the respective departments.

Note 2 - Line 24

The membership line item shows a 17 percent increase. This is based largely on the plans of that committee to hold a membership workshop in 1987.

Note 3 - Line 27

Maintenance agreements on certain pieces of Word Processing Equipment were not implemented at time of purchase. This has since been rectified and is reflected in the 1987 budget.

Note 4 - Line 31

The Third Party Plans Committee has been budgeted \$10,000 for the use of a consultant in their area.

Note 5 - Line 32

The expense of the Continuing Education Committee has been transferred into the Council on Education and Accreditation budget.

Note 6 - Line 41

The 19 percent increase in the Library budget is based on the anticipated continued increase in the volume of users.

Note 7 - Line 50

The Journal production costs, up 16 percent over the '86 budget, is based on full circulation.

1987 BUDGET / REVENUE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdgt/ 1986 Bdgt	LINE ITEM
MEMBERSHIP FEES							
Active	\$1,872,450	\$1,870,867	\$1,952,964	\$1,768,475	\$2,150,726	111%	1
Corporate	82,520	82,823	82,520	51,865	103,150	125%	2
Affiliate	0	4,050	0	0	5,200	ERR	3
Supporting	10,080	7,209	10,080	3,067	10,500	104%	4
Student	24,700	29,502	25,805	501	30,400	118%	5
Total	\$1,989,750	\$1,994,451	\$2,071,369	\$1,824,947	\$2,309,976	112%	6
ACCREDITATION							
Survey Revenue	16,500	26,250	33,200	9,200	33,175	100%	7
Grants - NDEB	15,000	15,000	15,000	15,000	15,000	100%	8
Grants - Transfer of Corporate Fee	62,175	61,722	62,175	47,260	124,350	200%	9
Total	\$93,675	\$102,972	\$110,375	\$71,460	\$172,525	156%	10
EDUCATION							
DAT Revenue	126,000	151,146	140,000	76,352	150,000	107%	11
Grants - Student Affairs	15,000	7,515	15,000	8,625	15,000	100%	12
Total	\$141,000	\$158,661	\$155,000	\$84,977	\$165,000	106%	13
COMMUNICATIONS							
NDHM Revenue	20,000	22,700	20,000	27,624	33,000	165%	14
Product Recognition	15,000	15,000	24,000	0	24,000	100%	15
Publications	70,000	78,728	75,000	9,907	80,000	107%	16
Convention	6,505	(52,758)	3,120	20,254	(5,000)	-160%	17
Total	\$111,505	\$63,670	\$122,120	\$57,785	\$132,000	108%	18
JOURNAL							
Advertising	410,000	387,509	430,000	128,244	490,800	114%	19
Subscriptions	15,000	14,639	16,000	12,972	16,000	100%	20
Other income	1,000	14,344	5,000	0	1,500	30%	21
Total	\$426,000	\$402,492	\$451,000	\$141,215	\$508,300	113%	22
OTHER							
Interest	85,000	139,963	90,000	17,194	90,000	100%	23
Rental income	178,734	173,539	178,282	47,646	172,203	97%	24
FJI Receipts	14,000	16,740	6,000	1,185	6,000	100%	25
Other income	0	84,360	0	1,033	0	ERR	26
Total	\$277,734	\$414,602	\$274,282	\$67,048	\$268,203	98%	27
GRAND TOTAL	\$3,039,664	\$3,135,848	\$3,184,146	\$2,247,433	\$3,536,004	112%	28

1987 BUDGET / REVENUE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg't/ 1986 Bgt
FEEs						
4000 009	\$404,325	\$391,837	\$421,711	\$366,273	\$466,574	111%
4000 008	273,825	257,738	285,599	269,448	315,982	111%
4000 007	81,675	71,775	85,187	77,315	94,249	111%
4000 006	101,775	100,350	112,409	604,908	124,367	111%
4000 005	580,725	585,956	605,696	292,981	670,132	111%
4000 004	264,150	303,932	275,508	45,031	304,817	111%
4000 003	45,450	43,200	47,404	82,429	52,447	111%
4000 002	78,075	76,275	81,432	9,675	90,095	111%
4000 001	9,225	9,225	9,522	30,315	10,646	111%
4000 010	27,225	30,129	28,396		31,417	111%
4100 009	14,680	14,992	14,680	20,533	18,350	125%
4100 008	9,735	9,709	9,735	9,529	12,170	125%
4100 007	2,904	2,771	2,904	4,524	3,630	125%
4100 006	3,832	3,697	3,832	0	4,790	125%
4100 005	33,816	33,816	33,816	0	42,270	125%
4100 004	11,600	11,608	11,600	9,960	14,500	125%
4100 003	1,864	1,864	1,864	1,632	2,330	125%
4100 002	2,776	2,688	2,776	4,615	3,470	125%
4100 001	344	585	344	0	430	125%
4100 010	968	1,093	968	1,072	1,210	125%
4001 011						
4200 001	0	4,050	0	940	5,200	ERR
4200 002	10,080	7,209	10,080	2,721	0	0%
4300 000	0	0	0	346	10,500	ERR
4700 000	24,700	27,138	24,700	492	30,400	123%
4740 000	0	1,076	0	13	0	ERR
4720 000	0	1,288	1,105	96	0	0%
ACCREDITATION						
4610 001	0	14,450	17,100	9,200	17,500	102%
4610 003	11,000	10,300	11,000	0	11,000	100%
4610 002	0	0	0	0	0	ERR
4615 000	5,500	1,500	5,100	0	4,675	92%
4620 000	62,175	61,722	62,175	47,260	124,350	200%
4600 001	15,000	15,000	15,000	15,000	15,000	100%
DATP						
4800 000	126,000	151,146	140,000	76,352	150,000	107%
GRANTS						
4710 000	7,500	6,375	7,500	1,125	7,500	100%
4712 000	7,500	1,140	7,500	7,500	7,500	100%
PRODUCT RECOGNITION						
4810 000	15,000	15,000	24,000	0	24,000	100%
PAMPHLETS						
4830 000	70,000	78,728	75,000	9,907	80,000	107%
4831 001	0	0	0	0	0	ERR
NAT. DENT. HEALTH MONTH						
4840 000	20,000	22,700	20,000	27,624	33,000	163%
NIDM income						
4820 000	6,505	(52,738)	3,120	20,234	(5,000)	150%
CIDA CONVENTION						
Annual Convention - Net						

15-Jul-86

(RBGT1987)

1987 BUDGET / REVENUE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdgt/ 1986 Bdgt
JOURNAL REVENUE						
Sale Of Journal	15,000	14,639	16,000	12,972	16,000	100%
Commercial Advertising Revenue	385,000	360,969	400,000	117,569	460,800	115%
Classified Advertising Revenue	25,000	26,540	30,000	10,675	30,000	100%
Sale Of Reprints	1,000	344	5,000	0	1,500	30%
CDA Internal Advertising	0	0	0	0	0	ERR
INTEREST						
Term Deposit Interest	25,000	61,620	40,000	6,221	40,000	100%
Current Account Interest	60,000	75,547	50,000	10,612	50,000	100%
Other Interest	0	2,796	0	361	0	ERR
RENTAL REVENUE						
Rental Income Escalation	6,200	6,015	6,200	6,461	6,500	106%
Rental Income - O.D.S.	41,900	41,706	41,900	13,300	53,941	100%
Rental Income - C.C.H.A.	2,520	2,520	2,520	13,902	53,941	129%
Rental Income - Clendenning	1,836	1,836	1,750	714	3,150	125%
Rental Income - F.M.W.	0	0	0	0	2,310	132%
Rental Income - SEVEC	0	0	0	0	60,120	ERR
Rental Income - Red Cross	6,360	5,355	6,360	5,355	23,867	ERR
Rental Income - Parking	11,245	5,532	12,852	2,189	6,120	96%
Rental Income - R.C.F.C.	70,994	5,890	70,994	0	0	0%
Rental Income - C.P.A.	36,973	69,572	35,000	17,885	0	0%
Rental Income - M.St.M.	0	34,513	0	0	0	ERR
Rental Income - Ste. 105	0	0	0	0	\$15,195	ERR
OTHER INCOME						
F.D.I. Pay./Rec.	14,000	16,740	6,000	1,185	6,000	100%
Other Income	0	77,022	0	0	0	ERR
Foreign Exchange	0	7,338	0	1,023	0	ERR
TOTALS	\$3,039,664	\$3,136,848	\$3,184,146	\$2,247,433	\$3,556,004	112%

1987 BUDGET / EXPENSE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg/ 1986 Bdg	LINE ITEM
EXECUTIVE							
Staff	\$169,315	\$64,900	\$160,700	\$59,574	\$220,267	137%	1
Management Committee	122,780	134,797	134,232	42,880	139,433	104%	2
Executive Council	74,847	85,498	68,908	18,540	66,142	96%	3
Executive Council Liaison	23,600	35,236	25,124	7,795	25,100	100%	4
President	73,085	82,174	65,200	27,285	66,550	102%	5
Taxation	4,215	3,638	7,878	2,379	3,057	39%	6
Constitution & By-laws	5,750	0	8,060	0	4,285	53%	7
Ethics	5,750	3,138	4,680	0	5,968	128%	8
Nominations	0	1,914	2,626	0	1,500	57%	9
Salaried Dentists	0	0	4,868	22	4,657	107%	10
Government Relations	0	325	26,408	2,822	2,500	9%	11
Board of Governors	90,517	86,170	99,824	39,947	83,925	84%	12
Specialty Sections	3,883	3,885	6,500	5,836	6,255	96%	13
Presidents & CEOs	10,950	9,042	11,102	0	9,738	88%	14
FDI Congress	0	16,084	20,500	6,725	20,000	98%	15
Legal	57,500	63,686	20,000	13,000	20,000	100%	16
Grants	12,000	11,500	11,000	0	13,000	118%	17
Awards	0	0	0	0	4,500	ERR	18
Other	33,000	47,094	35,190	13,674	30,457	87%	19
Unbudgeted Projects	50,000	52,696	30,000	19,332	20,000	67%	20
Total	\$737,194	\$701,777	\$742,300	\$252,811	\$747,335	101%	21
ADMINISTRATION							
Staff	\$262,053	\$575,409	\$324,879	\$91,770	\$215,326	66%	22
Operations	218,914	228,919	230,919	68,210	245,565	106%	23
Membership	50,873	44,172	57,828	15,724	67,567	117%	24
FDI Admin	20,000	29,679	20,000	1,223	20,000	100%	25
Equipment	50,000	42,633	41,000	18,593	41,000	100%	26
Data Processing	36,780	40,912	39,000	15,689	43,000	110%	27
Property	283,429	253,426	283,550	90,755	282,450	100%	28
Total	\$922,051	\$1,215,150	\$997,167	\$301,934	\$914,908	92%	29
ACCREDITATION							
Staff	\$104,200	\$36,288	\$100,512	\$33,893	\$135,188	135%	30
Third Party Plans	16,350	21,121	22,118	9,749	36,767	166%	31
Education & Accreditation	39,015	48,449	46,156	13,087	72,774	158%	32
School Surveys	34,800	26,810	81,900	36,582	62,770	77%	33
Health Care	26,810	25,204	19,826	2,432	18,416	93%	34
Hospital Services	21,185	19,304	33,870	11,930	20,685	61%	35
Hospital Surveys	15,200	9,587	8,280	0	12,525	151%	36
Dental Materials & Devices	17,775	11,769	17,534	47	15,797	90%	37
Total	\$275,335	\$229,600	\$330,216	\$106,720	\$375,922	114%	38
EDUCATIONAL SERVICES							
Staff	\$171,075	\$55,395	\$190,460	\$66,861	\$247,995	130%	39
Product Recognition	10,236	19,253	14,596	2,890	15,552	107%	40
Library	14,600	15,835	15,315	7,723	15,500	119%	41
Student Affairs	51,895	46,900	50,418	39,497	37,646	75%	42
DAI	124,850	118,112	133,160	39,497	115,256	87%	43
Information Services	434,463	489,965	378,600	179,639	360,643	95%	44
Conferences	22,500	11,155	22,500	7,433	18,000	80%	46
Total	\$829,331	\$743,133	\$805,247	\$308,567	\$813,692	101%	47
JOURNAL							
Staff	\$115,161	\$108,975	\$128,448	\$37,105	\$148,184	115%	48
Editorial Board	7,200	8,422	7,124	3,215	7,598	107%	49
Journal Production	352,500	356,641	391,320	122,352	452,646	116%	50
Journal Sales	95,810	84,744	95,300	30,171	91,130	96%	51
Total	\$570,671	\$558,782	\$622,192	\$192,843	\$699,558	112%	52
GRAND TOTAL	\$3,334,582	\$3,448,442	\$3,497,122	\$1,162,876	\$3,551,414	102%	53

1987 BUDGET / EXPENSE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg't/ 1986 Bdg't
EXECUTIVE OFFICE						
6000 090 Staff/Payroll	\$153,315	\$35,815	\$147,700	\$49,954	\$162,470	110% ERR
5000 030 Staff/Benefits-Transfer	0	0	0	0	26,597	ERR
5000 045 Staff/Misc. Expenses	10,000	0	0	0	2,200	ERR
5101 038 Staff/T&A-Executive Director	16,000	18,546	12,000	9,440	28,000	233% ERR
5100 038 Staff/T&A-Other	35,148	10,539	1,000	180	1,000	100%
5100 002 Management Committee/T&A	23,632	33,005	24,200	3,819	25,000	103%
5110 002 Management Committee/PD	69,420	39,459	35,152	14,101	36,558	104%
5110 085 Management Committee/Honoraria	35,427	41,944	74,880	24,960	77,875	104%
5100 001 Executive Council/T&A	10,000	43,554	32,580	6,810	32,040	98%
5100 003 Executive Council Liaison/T&A	13,600	15,024	36,328	11,730	34,102	94%
5110 003 Executive Council Liaison/PD	37,535	20,212	12,020	327	12,000	100%
5110 006 President's Expenses/PD	35,550	36,224	31,400	13,427	31,400	100%
5100 005 President's Expenses/T&A	2,265	45,950	33,800	13,858	35,150	104%
5110 005 Taxation Committee/PD	1,950	3,304	5,850	1,599	2,085	36%
5100 013 Constitution & By-Laws/T&A	5,000	3,334	2,028	780	3,475	48%
5110 013 Constitution & By-Laws/PD	750	0	6,500	0	3,811	53%
5100 014 Ethics/T&A	5,750	3,138	1,560	0	5,340	52%
5110 014 Ethics/PD	0	0	3,780	0	628	81%
5100 018 Nominations/T&A	0	0	1,950	0	1,500	77%
5110 018 Nominations/PD	0	0	3,676	0	0	0%
5100 021 Salaried Dentists/T&A	1,419	1,419	3,900	22	4,170	107%
5110 021 Salaried Dentists/PD	495	495	468	0	487	104%
5100 024 Government Relations/T&A	0	0	21,000	1,418	2,500	12%
5110 024 Government Relations/PD	325	325	5,408	1,404	0	0%
5100 025 Board Of Governors/T&A	66,000	57,491	70,340	27,050	53,325	75%
5110 025 Board of Governors/PD	24,517	28,679	29,484	12,897	30,600	104%
5100 026 Specialty Sections/T&A	3,885	3,885	6,500	5,836	6,255	96%
5100 027 Specialty Sections/PD	9,000	8,392	9,750	0	9,035	ERR
5110 027 Presidents & CEOs/T&A	1,950	650	1,352	0	703	93%
5100 028 FDI Congress/T&A	57,500	16,084	20,000	0	20,000	52%
5000 071 Legal & Consulting	12,000	63,686	20,000	6,725	20,000	98%
5000 076 Grants/Sponsorship	0	11,500	11,000	13,000	13,000	100%
5000 018 Awards/Nominations	9,000	4,256	0	0	4,500	118% ERR
5111 074 Other/CPP-Per Diem	9,000	0	11,190	1,620	4,457	40%
5110 099 Other/Misc. Per Diem	9,000	0	9,000	4,825	0	ERR
5110 090 Other/Unaccountable Expense	15,000	4,500	0	0	9,000	100%
5100 099 Other/Secretaries Conference	0	1,740	0	0	2,000	ERR
5101 006 Other/President's Installation	0	10,499	15,000	875	15,000	100%
5216 093 Other/Manpower Symposium	0	24,255	0	1,348	0	ERR
5217 Other/Roles & Responsibilities	0	0	0	502	0	ERR
5220 Other/Previous Year Expense	50,000	1,844	0	4,504	0	ERR
Unbudgeted Projects		52,696	30,000	19,532	20,000	67%
Total	\$737,194	\$701,777	\$742,300	\$252,811	\$747,335	101%

1987 BUDGET / EXPENSE

1985 (Adj) Budget 1985 Actual 1986 Budget 1986 (4mth) Actual 1987 Budget 1987 Bdg't/1986 Bdg't

ADMINISTRATION

6000 091	Staff/Payroll	159,646	40,984	170,285	58,145	187,314	110%
6000 031	Staff/Pension-Employer Paid	25,000	28,820	28,000	852	38,000	136%
6000 032	Staff/Special Benefits	5,000	54,035		2,027	6,000	ERR
6000 033	Staff/Canada Pension Plan	8,500	7,155	9,000	3,075	9,500	106%
6000 034	Staff/Unemployment Insurance	14,670	14,316	15,000	4,485	15,900	106%
6000 035	Staff/O.H.I.P.	7,700	7,602	8,000	2,604	8,500	106%
6000 036	Staff/Blue Cross	4,400	4,365	4,700	1,391	5,000	106%
6000 039	Staff/Payroll Contingency		350,589	43,000	0	0	0%
6000 061	Staff/Group Plan CDSPI/53745	5,800	22,875	6,200	1,400	4,500	73%
6000 062	Staff/Group Plan CDSPI/53744	25,000	4,226	29,000	10,040	31,500	109%
6000 063	Staff/Group Plan CDSPI/53744	4,000	3,639	4,200	1,520	4,750	113%
6000 073	Staff/Training		1,502	5,000	661	2,000	40%
6000 038	Staff/Personnel Advertising	1,000	1,658	1,000	272	1,000	100%
6000 099	Staff/Misc. Benefits	1,300	675		48	0	ERR
	Staff/Transfer Accounts-Exec					(26,597)	ERR
	Staff/Transfer Accounts-Accred					(22,481)	ERR
	Staff/Transfer Accounts-Educ.					(36,413)	ERR
	Staff/Temporary Accounts-Journal					(23,748)	137%
6000 030	Staff/Temporary	(15,961)	22,419	(17,306)	0	5,600	44%
	Staff/Misc. Expenses	2,000	399	2,000	4,843	0	ERR
6101 038	Staff/T&A Dir. of Administratio	0	910	1,800	78	2,000	100%
6100 038	Staff/T&A-Other	19,800	19,524	20,000	5,329	2,000	111%
6020 045	Operations/Office Supplies	50,000	52,364	52,000	18,110	21,000	105%
6020 054	Operations/Postage	4,400	3,395	4,400	3,199	55,000	106%
6020 055	Operations/Shipping And Deliver	670	400	500	300	7,500	155%
6020 056	Operations/Memberships & Subs.	1,000	2,203	1,000	0	500	100%
6020 057	Operations/Photography	0	658	0	176	0	0%
6020 069	Operations/Admin. Charges	0	7,115	5,000	0	550	ERR
6020 088	Operations/Ad Debt Expense	0	942	4,000	1,011	0	ERR
6020 099	Operations/Misc. Office Expense	2,200	67	4,000	6,857	5,000	100%
6021 045	Operations/Meeting Supplies	11,000	63,318	60,000	18,914	4,000	100%
6030 050	Operations/Tel. & Telegaph	42,000	13,303	44,500	2,262	12,000	108%
6030 052	Operations/Printing	0	1,934	2,000	295	31,000	70%
6030 053	Operations/Duplicating	2,644	644	2,670	0	15,500	ERR
6031 050	Operations/Other Telephone Exp.	10,200	10,271	11,000	3,475	765	114%
6040 062	Operations/Insurance-Exec Coun	5,000	4,526	5,000	0	13,750	125%
6040 064	Operations/Insurance-Gen & Liab	8,000	7,800	8,400	0	0	ERR
6040 065	Operations/Foreign Exchange	10,670	4,801	15,840	0	5,000	100%
6040 071	Operations/Legal	2,480	4,062	2,488	960	9,000	107%
6040 072	Operations/Audit And Financial	2,680	3,280	2,000	0	14,595	92%
6100 004	Membership/T&A	4,620	3,280	5,000	1,499	3,000	100%
6110 004	Membership/PD	9,773	9,080	7,000	5,773	20,000	13%
6400 058	Membership/Promotion	25,742	26,229	27,500	8,991	32,000	286%
6400 079	Membership/Campaign	20,000	29,679	20,000	1,223	20,000	100%
6500 079	F.D.I. Administration Expense	20,000	20,108	10,000	695	10,000	100%
6200 040	Equipment/Purchases	25,000	18,143	26,000	13,960	26,000	100%
6200 041	Equipment/Rental	5,000	4,382	5,000	3,838	5,000	100%
6200 042	Equipment/Maintenance	22,000	26,651	24,000	8,197	25,000	104%
6210 040	Data Processing/Expense	7,480	8,295	8,000	5,964	11,000	138%
6210 042	Data Processing/Maintenance	2,680	3,280	2,000	0	3,000	100%
6210 044	Data Processing/Software	4,620	3,280	5,000	1,499	3,000	100%
6300 046	Property/Dep n Expense - Bldg	60,000	56,063	60,000	17,563	53,000	88%
6300 070	Property/Mortgage Interest	60,000	49,994	60,000	14,363	50,000	83%
6300 074	Property/Realty Tax	49,400	49,398	53,000	23,761	61,000	113%
6310 047	Property/Light, Heat & Water	49,000	42,933	51,000	18,781	53,000	108%
6310 064	Property/Insurance-Building	4,500	4,391	5,000	1,503	5,000	100%
6320 042	Property/Plumbing & Electrical	1,375	2,206	1,500	0	1,500	100%
6320 045	Property/Bldg. Main.-Supplies	4,400	4,321	4,700	775	5,000	106%
6320 048	Property/Bldg. Main.-Labour	13,000	13,563	13,700	4,239	14,500	106%
6320 049	Property/Bldg. Main.-Security	1,800	1,400	1,900	4,700	2,000	105%
6321 049	Property/Fire Inspection	450	366	450	240	450	100%
6330 045	Property/Grounds Main.-Supplies	10,500	9,888	10,500	3,759	500	ERR
6330 048	Property/Grounds Main.-Labour	14,000	16,423	14,800	3,617	15,000	114%
6340 042	Property/Large Equip. Main.	13,354	1,180	6,000	0	1,000	101%
6350 097	Property/Renovations	1,650	2,046	1,000	453	1,500	100%
6350 099	Property/Miscellaneous						150%
Total		\$922,051	\$1,215,150	\$947,167	\$301,934	\$414,904	97%

1987 BUDGET / EXPENSE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdgt/ 1986 Bdgt
ACCREDITATION						
6000 092	89,200	24,213	94,552	32,211	104,007	110% ERR
7000 030	0	0	0	0	22,481	ERR
7000 045	0	0	0	0	2,200	ERR
7101 038	15,000	11,841	4,960	784	5,000	101% ERR
7100 038	13,950	234	1,000	898	2,500	250% ERR
7100 009	2,400	19,309	19,310	8,125	22,555	117% ERR
7110 009	20,620	1,812	2,808	624	4,212	150% ERR
7120 012	2,775	34,086	19,720	468	10,000	ERR
7130 012	2,945	476	10,112	2,278	19,200	97% ERR
8100 011	6,000	8,832	7,380	5,070	6,120	61% ERR
7110 012	6,675	7,109	5,200	3,400	8,010	109% ERR
8110 011	0	0	3,120	624	10,680	205% ERR
7210 092	24,800	32,924	48,240	21,156	15,000	166% ERR
7230 000	10,000	15,525	13,260	5,516	33,330	312% ERR
7200 095	22,110	21,104	20,400	9,900	15,190	69% ERR
7100 015	4,700	8,100	17,330	2,120	14,250	115% ERR
7120 016	9,560	4,927	2,496	312	14,850	70% ERR
7100 022	4,225	3,380	11,480	7,757	3,566	86% ERR
7110 016	7,400	5,225	5,294	1,467	8,900	143% ERR
7110 022	11,200	7,262	11,480	2,706	6,925	78% ERR
7220 092	4,000	2,325	3,120	0	0	131% ERR
7200 095	15,300	10,344	2,496	0	4,860	0% ERR
7100 020	2,475	1,425	6,480	0	0	156% ERR
7110 020	\$275,335	\$229,600	\$330,216	\$106,720	\$375,922	114% ERR
Total						

(1987EBCT)

1987 BUDGET / EXPENSE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg 1986 Bdg
EDUCATIONAL SERVICES						
6000 093	159,075	41,865	168,620	56,359	185,482	110%
8000 030	0	0	0	2,103	36,413	ERR
8000 045	0	0	0	3,342	12,600	ERR
8101 038	12,000	11,963	12,000	6,943	10,000	83%
8100 038	9,486	7,001	9,840	1,113	3,500	36%
8100 008	6,000	9,398	13,650	2,078	14,680	108%
8110 008	6,000	250	936	312	8,972	104%
8200 041	6,000	9,398	6,360	2,358	8,500	134%
8200 044	2,650	592	655	189	700	107%
8200 053	6,000	2,534	2,000	563	2,000	100%
8200 056	6,000	6,576	6,000	1,847	7,000	117%
8200 099	16,000	11,797	16,640	5,176	14,000	ERR
8110 019	1,500	3,690	3,588	312	1,296	20%
8300 051	2,500	5,851	3,000	0	1,000	84%
8300 058	11,500	2,458	3,000	23	2,500	36%
8300 068	7,000	5,644	12,190	0	7,000	83%
8300 076	800	6,513	1,000	500	7,000	57%
8300 084	10,000	9,557	1,000	0	850	100%
8300 093	2,305	1,375	4,000	0	4,000	85%
8300 099	37,000	21,923	22,220	1,703	0	ERR
8110 010	1,650	2,525	1,248	10,068	18,240	ERR
8400 045	29,500	5,588	42,000	1,717	1,296	82%
8400 051	22,500	54,995	24,700	574	20,000	104%
8400 052	3,700	8,868	9,000	9,970	32,000	48%
8400 055	12,000	657	8,000	4,358	9,000	ERR
8400 067	6,000	1,520	4,000	23	8,000	130%
8400 068	12,000	9,760	10,000	1,207	3,000	100%
8400 091	19,710	4,692	10,400	4,435	11,000	75%
8400 099	4,425	14,533	17,220	6,370	11,500	110%
8100 017	200,000	351,618	142,000	29,664	12,510	107%
8110 017	75,000	27,745	75,000	2,964	2,433	73%
8500 093	30,000	61,489	30,000	92,174	75,000	52%
8501 093	28,000	27,859	30,000	17,979	28,000	100%
8502 093	1,830	1,349	2,000	1,858	3,000	110%
8520 081	5,500	2,258	3,500	7,868	2,200	100%
8520 082	10,500	9,272	12,000	7,538	9,000	73%
8520 083	12,000	9,272	12,000	(105)	9,000	52%
8710 093						100%
8711 093						106%
						75%
						88%
						93%
						150%
						63%
						86%
						75%
Total	\$829,331	\$743,133	\$805,247	\$308,567	\$813,692	101%

15-Jul-86

(1987EBCT)

1987 BUDGET / EXPENSE

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg't/ 1986 Bdg't
JOURNAL						
9000 094	90,700	97,937	100,942	31,157	111,036	110%
9000 031	0	1,204	1,200	0	0	ERR
9000 030	0	0	0	1,309	4,400	137%
9000 096	15,961	2,182	17,306	3,197	23,748	ERR
9000 045	0	0	0	38	0	ERR
9001 038	8,500	6,206	6,000	527	6,000	100%
9002 038	6,750	1,446	3,000	876	3,000	100%
9100 007	450	7,747	6,500	2,903	6,950	107%
9110 007	20,000	18,351	22,000	7,312	648	104%
9200 051	92,250	119,781	100,800	7,238	16,000	73%
9200 052	12,000	10,628	12,720	32,561	100,800	100%
9200 055	18,000	13,619	20,000	7,223	26,246	206%
9200 059	197,750	182,760	216,100	2,447	15,000	75%
9200 084	1,000	1,827	5,000	70,060	274,000	127%
9200 085	8,000	8,068	9,200	1,425	4,000	80%
9300 077	3,500	1,607	3,500	1,200	9,800	107%
	0	0	2,000	0	4,800	137%
9300 038	6,000	8,091	6,600	2,230	2,000	100%
9301 066	8,800	6,741	9,200	4,051	6,600	100%
9300 050	5,000	5,109	5,000	1,267	13,160	143%
9300 058	10,000	12,066	8,000	1,696	5,300	106%
9300 066	57,500	53,561	60,000	16,723	8,480	106%
9300 072	1,200	1,192	1,500	1,135	55,000	92%
9300 094	2,310	(2,396)	5,000	3,070	1,590	106%
9300 098	5,000	3,380	5,000	0	0	ERR
Total	\$570,671	\$558,782	\$622,192	\$192,843	\$699,558	20%
						112%

(PROJ INCM)

1987 BUDGET - PROJECTED INCOME STATEMENT

	1985 (Adj) Budget	1985 Actual	1986 Budget	1986 (4mth) Actual	1987 Budget	1987 Bdg't/ 1986 Bdg't
REVENUE						
MEMBERSHIP FEES	\$1,989,750	\$1,994,451	\$2,071,369	\$1,824,947	\$2,309,976	112%
ACCREDITATION	93,675	102,972	110,375	71,460	172,525	156%
EDUCATION	141,000	158,661	155,000	84,977	165,000	106%
COMMUNICATIONS	111,505	63,670	122,120	57,785	132,000	108%
JOURNAL	426,000	402,492	451,000	141,215	508,300	113%
OTHER	277,734	414,602	274,282	67,048	268,203	98%
TOTAL REVENUE	\$3,039,664	\$3,136,848	\$3,184,146	\$2,247,432	\$3,556,004	112%
EXPENSE						
EXECUTIVE	\$737,194	\$701,777	\$742,300	\$252,811	\$747,335	101%
ADMINISTRATION	922,051	1,215,150	997,167	301,934	914,908	92%
ACCREDITATION	275,335	229,600	330,216	106,720	375,922	114%
EDUCATIONAL SERVICES	829,331	743,133	805,247	308,567	813,692	101%
JOURNAL	570,671	558,782	622,192	192,843	699,558	112%
TOTAL EXPENSE	\$3,334,582	\$3,448,442	\$3,497,122	\$1,162,875	\$3,551,415	102%
NET SURPLUS / (DEFICIT)	(\$294,918)	(\$311,594)	(\$312,976)	\$1,084,557	\$4,589	-1%

1986 PARTICIPATION AGREEMENT

SCHEDULE A - ALL PROVINCES OTHER THAN ONTARIO AND QUEBEC

Sponsored Plans

Basic Life Insurance

Dependents' Life Insurance

Accidental Death and Dismemberment Insurance

Long Term Disability Insurance

Office Overhead Expense Insurance

Business Interruption Insurance

Office Contents Insurance

General Liability Insurance

Malpractice Insurance

1986 PARTICIPATION AGREEMENT

SCHEDULE A - ONTARIO

Sponsored Plans

Basic Life Insurance

Dependents' Life Insurance

Accidental Death and Dismemberment Insurance

Long Term Disability Insurance

Office Overhead Expense Insurance

Business Interruption Insurance

Office Contents Insurance

General Liability Insurance

1986 PARTICIPATION AGREEMENT

SCHEDULE A - QUEBEC

Sponsored Plans

Basic Life Insurance

Dependents' Life Insurance

Accidental Death and Dismemberment Insurance

Long Term Disability Insurance

Office Overhead Expense Insurance

Malpractice Insurance

1986 PARTICIPATION AGREEMENT

SCHEDULE B

CDIP Plans

Basic Life Insurance

Dependents' Life Insurance

Accidental Death and Dismemberment Insurance

Long Term Disability Insurance

Office Overhead Expense Insurance

Business Interruption Insurance

Office Contents Insurance

General Liability Insurance

Malpractice Insurance

PROPOSED AMENDMENTS TO PARTICIPATION AGREEMENTS

TO BE ENTERED INTO AS OF JANUARY 1, 1987

1. Recital C. of each of the 1986 Participation Agreements shall be amended by deleting the words "one or more of" after the words "participate in the sponsorship of" in such Recital.

2. Section 3 of each of the 1986 Participation Agreements shall be deleted and the following shall be substituted therefor:

" 3. Participation

Subject to termination pursuant to Section 4, the Co-Sponsor shall participate in the sponsorship of each of the Plans listed in Schedule A. "

3. Section 4 of each of the 1986 Participation Agreements shall be deleted and the following shall be substituted therefor:

" 4. Termination of Participation

The Co-Sponsor shall be entitled, upon giving written notice to CDA on or before April 1, 1987, to terminate, effective as of January 1, 1988, its participation in the sponsorship of all, but not less than all, of the Sponsored Plans.

CDA shall give written notice to the Co-Sponsor, on or before July 1, 1987, of any Sponsored Plan which will not be made available to the Co-Sponsor for sponsorship during the year commencing January 1, 1988 so as to permit the Co-Sponsor to make arrangements to provide another plan to its members in replacement of or substitution for such Sponsored Plan. "

4. Schedule B of each of the 1986 Participation Agreements shall be deleted.

/ml

PROPOSITIONS D'AMENDEMENT AUX ENTENTES DE PARTICIPATION

QUI ENTRERONT EN VIGUEUR LE 1ER JANVIER 1987

1. L'Attendu C de chacune des ententes de participation de 1986 est modifié en remplaçant les mots "d'un ou de plusieurs pareils" par le mot "de tels" après l'expression "participer au parrainage" qui paraît dans ledit Attendu.
2. L'article 3 de chacune des ententes de participation est remplacé par ce qui suit:

" 3 Participation

Sous réserve des dispositions de cessation de l'article 4 ci-dessous, le co-parrain participe au parrainage de tous les régimes énumérés à l'annexe A. "
3. L'article 4 de chacune des ententes de participation est remplacé par ce qui suit:

" 4 Cessation

Le co-parrain a le droit de mettre fin, à compter du 1er janvier 1988, à sa participation au parrainage de tous les régimes parrainés, mais non pas à une partie d'entre eux seulement, en autant qu'il en donne l'avis par écrit à l'ADC au plus tard le 1er avril 1987.

L'ADC avisera le co-parrain par écrit, au plus tard le 1er juillet 1987, du retrait à compter du 1er janvier 1988 de tout régime offert au parrainage du co-parrain, afin de permettre à celui-ci de prendre les dispositions nécessaires pour offrir à ses membres un autre régime en remplacement dudit régime.
4. L'Annexe B de chacune des ententes de participation est supprimée.

/ml

CDA Position On

A CERTIFYING BOARD FOR GENERAL DENTISTRY

The Canadian Dental Association opposes the establishment of a Certifying Board for General Dentistry for the following reasons:

National certification of dental practitioners is currently the responsibility of the N.D.E.B. of Canada, a body established under Federal legislation. The NDEB certificate is recognized, for purposes of licensure, in all provinces. The evolution of this national certifying process - a development not paralleled in the United States - represents an accomplishment worth preserving. The need for a separate and distinct certificate from a Certifying Board For General Dentistry is not apparent and could compromise this achievement.

In addition, Undergraduate Dental Education in Canada is in the fortunate position of having current graduates of CDA accredited educational programs recognized for NDEB certification without further examination. Such a process of recognition grants the fullest degree of autonomy and respect to accredited educational programs. A new and separate certifying examination would be a retrograde step.

Preparation of the general dental practitioner remains the primary goal of the undergraduate dental education programs whose graduates are certified by the NDEB in this fashion.

There are a number of groups currently involved with continuing education for general dental practitioners, including CDA, NDEB and provincial licensing authorities working in co-operation with Canadian Faculties of Dentistry. At the request of the NDEB, CDA is currently exploring means of developing continuing education programs linked to the specific needs of individual general dental practitioners concerned with maintenance of professional competence.

The introduction of a certifying board for general dentistry would establish two levels of general practitioners and unnecessarily create disunity in a profession founded on the principle that all dentists must be general practice dentists, regardless of additional specialization in specific fields of interest. Completion of an approved undergraduate educational program in dentistry should continue to be the fundamental prerequisite for recognition as a general dental practitioner. The National Dental Examining Board Certificate should continue to provide the basis for national portability. An additional certificate is not required to attest to the skills, value or worth of the basic Canadian dental practitioner nor to achieve national portability of general dental practitioners.

BJH:dh

Nov.29, 1985



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 21, 1986.

Dr. Dan H. Loving, President,
The Certifying Board of General Dentistry,
211 East Chicago Ave.,
Suite 1200,
Chicago, Ill. 60611-2670

Dear Dr. Loving:

Dr. Bradley Holmes, President of the Canadian Dental Association, Mr. Brian Henderson, CDA Director of Accreditation and I were pleased to meet last week in Toronto with you and Dr. Robert Patrick. The meeting provided an opportunity to discuss plans to establish a Certifying Board of General Dentistry certification process in Canada.

As noted at the meeting, a number of questions will arise when the subject is presented to the CDA Board of Governors. We agreed that it would be appropriate to provide you with a number of the principal questions by letter and to convey your responses directly to each member of the CDA Board of Governors.

I have enclosed a list of such questions for your consideration and response. I trust that our meeting, your responses to these questions and the documentation we shall convey to the CDA Board on your behalf will ensure fair and complete consideration of the issue.

On behalf of my colleagues, I wish to thank you and Dr. Patrick for taking the time to meet with us and for the additional efforts being made to assist fruitful discussion by the CDA Board of Governors.

Yours sincerely,


A. Jardine Neilson,
Executive Director.

dh

Encl.

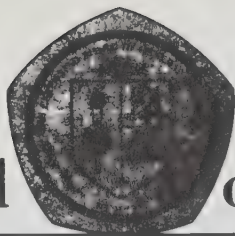
Questions Concerning the Proposal to Establish
An Academy of General Dentistry Certification Process in Canada

1. Why is the A.G.D. Certification Process needed? How did it develop in the U.S.A.? What evidence is there of a specific need in Canada? How will the recipient use such a certificate to advantage?
2. What sort of recognition is the Certificate actually intended to signify? How does this recognition compare with the recognition of Dental Specialists? How does it compare with the awarding of recognition as a "fellow" in the Canadian context, where "fellow" is a term traditionally reserved to recognize a distinguished specialist? Is such a certification process an "end run" on the usual and closely guarded procedure of first obtaining ADA/CDA recognition for a dental specialty or equivalent, and subsequently establishing a certification process?
3. The Canadian Dental Association and the National Dental Examining Board are currently developing a pilot project which would allow Dentists in general practice to test themselves, on a confidential basis, and follow up with specific continuing education offerings to make up any deficiencies identified. How does the A.G.D. certification process relate to this initiative? How is the need it is intended to serve distinct from the need this process might meet?
4. There are some indications that provincial governments may, sometime in future, require professional groups to demonstrate that the profession has clearly provided a process for verification of the continuing competence of individual professionals. How would the AGD Certification Process relate, in all probability, to such a development?
5. The National Dental Examining Board of Canada has been established, under federal legislation, as the body responsible to "determine and establish the qualifications or conditions under which a person may OBTAIN and HOLD a certificate of qualification", the NDEB Certificate. The NDEB is responsible for a single standard national dental certificate of qualification which may be recognized by the dental profession as the highest in Canada.* How would the AGD certificate relate to the NDEB certificate? Is it intended to be recognized as lesser, equivalent, greater? If it is not comparable in these terms, how is it related to the "qualification" of a dentist if it does not intend to delineate another category of accomplishment?

BJH:dh
May 21/86

* Quotations are from sections 7B and 6A of An Act to Incorporate The National Dental Examining Board of Canada.

The Certifying Board of General Dentistry



211 East Chicago Ave., Suite 1200, Chicago, IL 60611-2670 (312) 440-4300

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ynthia M. Costantino
Executive Secretary

June 6, 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, ON K1G 3Y6
CANADA

Dear Jardine:

Our recent conference was very helpful to me in understanding the situation in Canada. We appreciate the letter from the CDA requesting information about the Certifying Board of General Dentistry.

As I stated in the meeting in Toronto, the CBGD is not requesting approval by the CDA. Perhaps the CDA can agree to defer or postpone action on the proposed position statement, continue to monitor developments of the Certifying Board and, at a later date, make a decision as to whether the Certifying Board is of benefit to Canadian dentists. That position will allow greater interchange and liaison between the two groups, for mutual benefit.

The documents I left with you for inclusion in the Board booklet should aid in promoting greater understanding of the CBGD certification process for your members. They are: "Why Certification?", an Historical Overview, the 1986 Report of the Certifying Board of General Dentistry, and my letter to Brad Holmes in response to the CDA position paper on the CBGD.

Jardine, you noted that the CDA has five broad questions concerning how the CBGD process will benefit Canadian general dentists. I have taken the liberty of paraphrasing them, and I will respond to each one below.

1. Why is there a need for a certification process for general dentists? What evidence is there of a specific need in Canada?

Jardine, please refer to the "Why Certification?" document. (I have enclosed another copy.) The primary reason there is a need for certification is stated in the third paragraph of the enclosed document:

Mr. A. Jardine Neilson
June 6, 1986
Page 2

"General dentists have no access to a credential testifying to proficiency, as does virtually every other health professional. Health care institutions and government agencies, therefore, have no mechanism that allows them to recognize a general dentist's expertise when considering dentists for appointments, privileges, and promotions. A credential that represents an examination process similar to those of other health professionals will encourage recognition of general dentists' expertise, resulting in an increase in the number of competent general dentists in leadership, staff, and training positions."

In some instances, general dentists have been denied leadership positions in general dentistry residency programs and in other institutional settings because of the lack of a credential that they have not had the opportunity to earn!

It may be that there is no great need in Canada, at the present time, for a Certifying Board of General Dentistry. However, since the Board was created by the Academy of General Dentistry, an international organization, it is appropriate that the CBGD also be international in scope. There are those persons in Canada who believe they can benefit from such a procedure. Currently, two Canadians are applicants to the Board for Educationally Qualified for Certification status.

2. Compare the CBGD certificate with specialists' certificates, and to a Canadian "fellow" (a distinguished specialist). Is the CBGD process intended to bypass the usual ADA/CDA processes for specialty board recognition?

Jardine, there is similarity between the CBGD credential and the specialist's credential, in that both allow for promotion of dentists in the military and in hospital and academic settings. However, while specialists can advertise their board certification to the public, general dentists are not specialists. The CBGD certificate is a document internal to the profession. It cannot be used to advertise superior skills to the patient, or it will be withdrawn. Each candidate signs a statement that he/she understands this and agrees to surrender the certificate if it is misused. Also, the person who does not conform to the rules will not be recertified at the appropriate time. Most of the persons in the USA who will benefit from board certification are military, academicians, those who practice for governmental agencies when promotion is tied to certification, and those in administrative positions; i.e., insurance companies, etc. Private general practitioners will seek board certified status as a personal goal and for their own satisfaction.

Mr. A. Jardine Neilson
June 6, 1986
Page 3

This board does not intend to bypass traditional ADA/CDA recognition procedures for credentialing bodies. However, at this time, neither the ADA nor CDA have procedures that recognize non-specialty boards. As you are aware, AGD and ADA are discussing the concept of a non-specialty certifying board; i.e., for general dentistry, implantology, oral medicine, operative dentistry, and other groups. ADA is in the process of appointing an ad hoc committee to develop guidelines to monitor non-specialty boards. This Board will review them and follow up with procedures that address ADA requirements.

3. Compare/contrast the CBGD process to the Canadian initiative for testing deficiencies of general dentists confidentially, offering these dentists the opportunity to seek specific CDE to remedy their weaknesses.

Jardine, this process sounds similar to the function served by AGD's Fellowship Exam. Of course, dentists who progress through the board certification process will also be in a better position to assess their relative weaknesses, but that it not the primary "mission" of board certification. However, the CBGD process could make available more high quality CDE courses that dentists who use the Canadian self-assessment devices would be able to attend. The development of the written exam, the domain of general dentistry, and the protocol for the certification exam (oral defense of cases) will, over a period of time, effect change in continuing education by providing incentives for more participation courses and possibly a continuous, sequential curriculum (like that found at the University of Florida), to achieve preparation for becoming certified.

4. How will the CBGD process relate to the future Canadian requirement of ensuring continued competence by some type of verification procedures?

Certified general dentists will certainly meet the continuing competence standards that may be required by provincial governments. The CBGD will require Board certified general dentists to attend a certain amount of continuing education courses in order to be recertified. Recertification will be required on a five-year basis.

5. How will the CBGD certificate relate to the NDEB certificate?

The Canadian system uses the word "certificate" to attest to licensure. In the U.S., licensure is granted to dental school graduates who meet minimum competency standards in general dentistry. In contrast, the CBGD will certify persons only after a minimum of seven years of experience in the dental profession, and only after they meet certain academic and clinical requirements demonstrating their

Mr. A. Jardine Neilson
June 6, 1986
Page 4

proficiency in all 11 areas of general dentistry. Please refer to my letter to Brad Holmes for further details.

Overall, my perception is that the CDA and the CBGD have complimentary goals:

1. The protection of the public
2. The improvement of the profession
3. Encouragement of members of the profession to achieve their greatest level of potential
4. The development of increasingly helpful continuing education programs

Let me restate the hope of the CBGD that the CDA will defer action on the proposed policy statement until such time as a clearer picture of the effect on Canada is available.

Yours for better dentistry,

Dan

Dan H. Loving, DDS
President

Enclosure

cc: Bradley Holmes, DDS
President, Canadian Dental Association

John R. Robertson, DDS
President-elect, Canadian Dental Association

Mr. Brian Henderson
Director of Accreditation, Canadian Dental Association

W. Robert Patrick, DDS

The Certifying Board of General Dentistry



211 East Chicago Ave., Suite 1200, Chicago, IL 60611-2670 (312) 440-4300

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bert B. Mayhew, DMD
thony H. L. Tjan, DDS

nthia M. Costantino
Executive Secretary

WHY CERTIFICATION?

The Academy of General Dentistry's 1979 House of Delegates approved formation of a 10-member ad hoc committee to study the issue of certification for general dentists. AGD's Council on Continuing Dental Education proposed this study, based on increasing concern about the issue among AGD members and constituent academies. The committee concluded that there was a need for a certification program in general dentistry, and AGD's 1979 House of Delegates concurred.

The conclusions reached by the committee and AGD's House of Delegates concerning the need for a gp certification process can be summarized as follows:

General dentists have no access to a credential testifying to proficiency, as does virtually every other health professional. Health care institutions and government agencies, therefore, have no mechanism that allows them to recognize a general dentist's expertise when considering dentists for appointments, privileges, and promotions. A credential that represents an examination process similar to those of other health professionals will encourage recognition of general dentists' expertise, resulting in an increase in the number of competent general dentists in leadership, staff and training positions.

There is currently no objective measure of skill and proficiency in general dentistry. An independent certification process that maintains high standards with consistency can provide such a measure.

A credible certification process will ultimately improve undergraduate, and especially postgraduate, general dentistry training programs. The Certifying Board of General Dentistry is currently working very hard to enforce high standards among its applicants for Educationally Qualified for Certification status, and to establish high standards in its examination programs. If the standards for certification are high, training programs will improve to meet those standards. Further, it is likely that certification will eventually allow general dentists to head general dentistry residency and postgraduate programs.

The ultimate goals in establishing a national certifying board in general dentistry are the traditional goals of any professional certification program: To increase the standards of dental patient care and dental training.

THE NATIONAL DENTAL EXAMINING BOARD OF CANADA
LE BUREAU NATIONAL D'EXAMEN DENTAIRE DU CANADA

100 BRONSON AVENUE, OTTAWA, CANADA, K1R 6G8 (613) 236-5912

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Council on Education and Accreditation, CDA:
Dr. A. Schwartz
Dr. G. S. Beagrie

June 5, 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Mr. Neilson,

Re: Academy of General Dentistry Certification Process in Canada

In response to your request, the President of The National Dental Examining Board of Canada has asked me to express the views of the NDEB on the abovementioned issue as follows:

1. The NDEB is in full agreement with the «CDA Position on a Certifying Board for General Dentistry» - Appendix D of the Executive Council Report - CDA Board of Governors' Meeting - April 1986 (attached).
2. To our knowledge, the AGD is a voluntary organization which promotes dissemination of dental knowledge and as such compares to any study club. The NDEB supports the ideals and efforts of such organizations within that context only.
3. The NDEB Act of Incorporation (1952) states that:

«6. The purposes of the Board shall be
a) to establish qualifying conditions for a single standard national dental certificate of qualification, which may be recognized by the dental profession as the highest in Canada;»

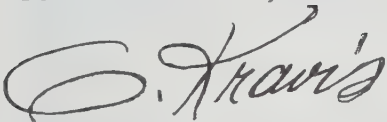
.../2

- 2 -

The NDEB has the definitive legal authority to issue certificates to dentists in general practice on the basis of an applicant's competence. This certificate is recognized as the highest in Canada. The introduction of any other national certificate for general practice dentists in Canada would be legally questioned by the NDEB.

The NDEB is concerned about the intentions of the AGD in the area of certification and hopes that the CDA will take a strong and negative position on this issue.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "G. Kravis".

G. Kravis, D.D.S.
Registrar

GK/kh

cc: NDEB Executive

The Certifying Board of General Dentistry

211 East Chicago Avenue, Suite 1200, Chicago, IL 60611-2670

June 6, 1986

Mr. Brian Henderson
Director of Accreditation
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, ON K1G 3Y6
CANADA

Dear Mr. Henderson:

Dr. Bob Patrick asked me to provide you with a copy of the Certifying Board of General Dentistry's 1986 Annual Report to the Academy of General Dentistry's House of Delegates. Also enclosed is a copy of CDA's concerns regarding the certification of general dentists provided to Dr. Dan Loving, the Board's president, by Mr. Jardine Neilson, and Dr. Loving's response.

Please contact me if you would like any additional information.

Sincerely,

Cindy Costantino
Executive Secretary

cc: Dr. W. Robert Patrick

1986 ANNUAL REPORT OF
THE CERTIFYING BOARD OF GENERAL DENTISTRY

The Certifying Board of General Dentistry met twice since the Academy of General Dentistry's House of Delegates session in 1985: for three days July 30-August 1, 1985 in Detroit, and for three days October 3-5, 1985 in Chicago. The Board will hold two more meetings before the close of its 1985-86 operating year: May 29-31, 1986 in Chicago, and July 16-17, 1986 in Philadelphia.

The Board meetings held in July and October of 1985 were devoted to finalizing rules and procedures, as follows: the 'Route to Certification' was finalized, the educational entry criteria were established in final form, applications and mechanisms for evaluating them were developed, fees were established, and much work was completed on planning and development for both examinations.

The Certifying Board's Rules and Procedures were published in early 1986. A successful first audit was completed. Potential candidates for certification were contacted, and applications and fees for Educationally Qualified for Certification status were received during the first four months of 1986.

The 'Route to Certification'

The Academy of General Dentistry's 1984 House of Delegates recommended that the Board consider increasing the years of practice experience required at certification Entry Points I and II. There was also discussion in 1984 and 1985 that the course hour requirements of Entry Point III might be too high compared to what is required of candidates entering the process at Entry Points I, II or IV.

The Certifying Board revised the 'Route to Certification' based on these recommendations. The final version was established after careful consideration of when "years of practice experience" actually begin. Immediately after dental school graduation? Immediately after advanced formal education is completed? What if a dentist practices a few years after dental school graduation and then completes a

formal education program? Do the years between dental school and the start of the advanced education program "count," since some might say that the nature of practice and of the experience would change substantially after intensive post-graduate training? These are just some of the questions the Board pondered before making final changes in the 'Route to Certification.'

It was decided that it is impossible to anticipate all of the types of practice experiences obtained after dental school graduation, and equally impossible to equate these prior to the administration of the written examination for Board eligibility. The Board decided to establish strict educational requirements for each Entry Point, and to ensure that a minimum number of CDE course hours were attended in specific dental subject categories.

A dentist must have graduated from dental school and completed these educational requirements prior to taking the written examination, no matter how long it took any individual to meet the educational requirements. The "years of practice experience" or the "minimum time between dental school graduation and eligibility to take the practical Certification Examination and become certified" would be considered after the candidate passes the initial written examination and becomes Board Eligible. The Board assumes that, in order to successfully complete the educational requirements and pass the comprehensive, clinically-oriented written examination, the candidate would have to have had much practice experience. The written examination is not designed so that it can be passed through completion of course work and accumulation of factual knowledge only. For this reason, the Board established the following guidelines:

"Every dentist who is declared Board Eligible (that is, who has met the educational requirements and passed the written examination) must have graduated from an ADA or CDA accredited dental school at least 7 years before being eligible to take the Certification Examination."

(NOTE: the Certification Examination will entail presentation of cases and oral examination.)

The Board modified Entry Points II and III in an attempt to equate, as much as possible, the formal advanced and the continuing education experiences required of candidates following dental school graduation and licensure. The Board established the following education requirements for the four Entry Points to certification:

- Entry Point I: a. Successful completion of a two-year advanced formal education program in general dentistry which is accredited by the Commission on Dental Accreditation of the American Dental Association or the Canadian Dental Association.
- b. Documented attendance at a minimum of 100 clock hours of continuing dental education courses.

- Entry Point II: a. Successful completion of a one-year advanced formal education program in general dentistry which is accredited by the Commission on Dental Accreditation of the American Dental Association or the Canadian Dental Association.
- b. Documented attendance at a minimum of 600 clock hours of continuing dental education courses; of the 600 clock hours required, at least 200 must be in participation courses.

- Entry Point III: Documented attendance at a minimum of 1400 clock hours of continuing dental education courses; of the 1400 clock hours required, at least 500 must be in participation courses.

- Entry Point IV: Attainment of the status of Master of the Academy of General Dentistry.

A copy of the final 'Route to Certification' is appended to this report.

Rules and Procedures

The Certifying Board has completed and published its Rules and Procedures. In addition to the general Entry Point requirements previously discussed, the Board developed definitions of terms, criteria for acceptance of continuing education credits, application procedures, fees and final descriptions of the contents of both the written and the certification examinations.

A copy of the 'Rules and Procedures of the Certifying Board of General Dentistry' is appended to this report for the information of the AGD House of Delegates.

Solicitation of Prospective Candidates

The Board determined that the following groups of dentists would be contacted to inform them of the existence of the Board and the opportunity to apply for Educationally Qualified status: (1) graduates of 2- and 1-year advanced formal education programs in general dentistry; (2) AGD Fellows with at least 1000 post-FAGD credits; (3) AGD Masters; (4) directors of accredited formal advanced education programs in general dentistry; (5) dentists who requested information and applications, but whose names were not included in the above lists; and (6) 1986 AGD Mastership candidates.

Qualifying Applications were to be submitted to the Board by April 30, 1986 (May 15, 1986 for 1986 MAGD candidates). As of April 10, 42 applications had been received, more than half being from AGD Masters whose application forms were by far the simplest to complete. It is likely that most of the applications will be received close to the deadline. A substantial number of these applicants have also submitted an application to take the first written examination next March. 1986 graduates of formal advanced education programs in general dentistry will be mailed information and applications this summer.

Examination Development

Two examinations must be passed before a dentist can be certified: (1) a criterion-referenced, multiple choice written examination which must be passed to attain Board Eligible status, and (2) a Certification Examination,

which will consist of preparation and presentation of cases, and oral examination on the cases and on areas of dentistry not covered during the case questioning.

The Board will offer its first written examination on March 9, 1987 at Baylor College of Dentistry in Dallas, Texas. Eligible dentists will also be able to arrange administration of the exam at a DANTES site.

The written examination will be 6 hours in duration. The 400 multiple choice and clinical simulation problems are based on a specified domain of general dentistry knowledge, skill and procedures. The subjects tested, and the number of questions in each, are outlined in the attached 'Rules and Procedures.'

The Board developed weighted content outlines for each subject in 1984. Each exam question is based on these weighted outlines. This procedure will build content validity into the examination.

The Board has developed over 800 questions for the written exam thus far. Each question is being reviewed and edited several times, with the assistance of staff and Board members who have expertise in examination development. The Board intends to have between 1000 and 1200 questions available before the 1987 examination is finalized.

The Board is currently developing a study guide for the written examination, which will be available in September 1986.

After candidates pass the written exam, they are Board Eligible, and they are eligible to take the practical Certification Examination. The specific requirements for the Certification Examination are outlined in the attached 'Rules and Procedures.'

The Board will publish specifications for required cases by June 1987.

Board Operations

At its Annual Meeting in July 1985, the Certifying Board elected Dr. Dan H. Loving as president, Dr. E. Mac Edington as vice president, Dr. Clifford H. Miller as treasurer, and Dr. J. Frank Collins as secretary. Officers are elected annually.

The terms of office of three of the nine members of the Board expire at the close of the AGD House of Delegates in 1986. As stipulated by its Bylaws, the Board recommended six dentists for the three vacancies to the AGD Board of Directors last January. The AGD Board will submit its nominations for election to the Certifying Board to the 1986 House of Delegates, which will elect the new Board members.

The Board performed an annual review of its Constitution and Bylaws in October, 1985. No changes were made to these documents.

The Board submitted an application to the Internal Revenue Service for tax-exempt status, and a decision will be rendered by June, 1986. A tax return, based on preliminary tax-exempt status, was filed last March. The Board has applied for a non-profit mailing permit that will allow the Board to send bulk mailings at below the regular bulk postage rate.

The Board accepted and evaluated applications from dentists interested in becoming Educationally Qualified for Certification this last spring. These dentists will be notified of the status of their applications this summer.

In order to prepare to administer the first written examination in March, 1987, the Board has much work ahead of it. Between now and May, 1987, when scores for the first written exam will be released, the following tasks must be completed:

- * write additional exam questions so that all points outlined in the domain of general dentistry are adequately covered;
- * choose 400 representative questions from this pool;
- * carefully do a final review and edit of these questions;
- * design and print the examination;
- * design and print answer sheets & score report forms;

- * determine the pass/fail score;
- * administer the examination;
- * complete preliminary scoring;
- * analyze the raw scores and the performance of each of the individual 400 questions;
- * validate the exam;
- * prepare final scores based on validation results.

General information and Qualifying Applications will again be mailed (in January, 1987) to potential candidates, and these applications will be evaluated by June, 1987. The Board will always continue to develop, edit and refine questions for the written examination. And, case specifications for the Certification Examination will be developed by June, 1987.

Finances

The Board underwent a successful audit of its accounts for operations during its first fiscal year, October 18, 1984 through August 31, 1985. (Subsequent to that first year, the fiscal year will always be September 1 through August 31.)

The 1984 AGD House of Delegates provided the Board with loans of \$25,000 in cash and up to \$24,660 in staff support for operations during its 1984-85 fiscal year. The loans must be repaid to AGD by October 31, 1994. At the end of its first year, on August 31, 1985, the Board had a positive cash balance of \$2,301. The actual cost of AGD staff support for that first year was \$23,517.12, and the Board signed a note for that amount.

The 1985 AGD House of Delegates provided the Board with a \$27,000 cash loan and voted to provide up to \$20,500 worth of staff support. With the \$2,301 remaining from 1984-85, the Board began the 1985-86 fiscal year with a cash balance of \$29,301. As of April 15, 1986 (the date on which this report is being written), the Board had generated additional income from application fees in the amount of \$12,695. Therefore, as of 4/15/86, available operating funds for 1985-86 totaled \$41,976.

With regard to expenditure for 1985-86, the Board had expended \$16,500 as of April 15, 1986 for meetings, printing, postage, attorney and auditor fees, bonding and computer programming.

ANNUAL REPORT OF THE CERTIFYING BOARD OF GENERAL DENTISTRY
Page 8

The Board projects that expenditures of approximately \$16,400 will be required for the balance of the 1985-86 year for two meetings, printing of exam study materials, and postage for mailings to new residency graduates and dentists judged Educationally Qualified.

In summary, the Board anticipates total expenses for 1985-86 to be approximately \$32,900. Funds available as of 4/15/86 total \$41,976. Therefore, even without additional income during 1985-86, the Board would start 1986-87 with over \$9,000.

As noted above, income from application fees totaled \$12,695 as of 4/15/86. The income represented application fees for 43 Qualifying Applications and 10 written examination applications. Dentists whose Qualifying Applications are judged acceptable will have to take the written examination between 1987 and 1991. Those who decide to sit for the written exam in 1987 must remit the \$300 fee by January 1, 1987. It is impossible to predict, at this time, if all of those who have submitted Qualifying Applications will be accepted, and if they are, whether or not they will decide to sit for the written examination in 1987.

The Board hopes to receive a substantial number of additional Qualifying Applications between April 15, 1986 and May 15, 1986. At this time, however, the number cannot be accurately estimated.

The Board estimates the expenses for 1986-87 will total approximately \$31,000---for three Board meetings, one of which will be prolonged in order to analyze and score the written exam; for exam administration costs; for attorney and auditor fees; for postage; and, for computer time for scoring and generating question performance statistics for the 3/87 written exam.

Though the Board is confident that additional income will be generated this year, as well as next year, specific income predictions are difficult. If another 50 Qualifying Applications were received this year, along with another 35 applications for the written exam, additional income could be realized in the amount of \$21,750 for this fiscal year. Added to the projected \$9,000 surplus at the end of this year, it might be possible for the Board to cover its projected 1986-87 expenditures. Some amount of income will

be generated, as well, during 1986-87, though the total will almost surely be lower than for 1985-86. The Board is hopeful that the income generated by 1986-87 application fees will cover the projected 1987-88 expenses. The Board will be in a better position to judge whether or not this expectation is realistic in early 1987.

It is likely that the Board would not be to the point of generating income from application fees without the assistance of AGD staff. The Board believes that AGD staff input will be critical to developing and validating its first written exam, in continuing to process applications, in developing the certification exam, and in serving as a very important liaison between AGD and the Certifying Board. The Board cannot meet its current objectives without continued AGD staff assistance. For these reasons, the following resolution is being presented to AGD's House of Delegates:

"Resolved, that the Certifying Board of General Dentistry be provided with the resources necessary for its operation during the Academy of General Dentistry's 1986-87 fiscal year, in the form of (1) professional and administrative staff support; and (2) incidental office supplies and services necessary for routine operation, and be it further

Resolved, that before such resources be made available to the Certifying Board of General Dentistry, the Certifying Board agree to repay to the Academy, within 10 years, the monies loaned to it by the Academy, specifically the cost to AGD of providing professional staff support up to \$25,500, such repayment obligation to be interest-free for the first six years and the balance thereafter repaid at 1% above the then prime interest rate."

Each Board member wishes to express his thanks to AGD for all of its support, both financial and philosophical. The members feel a special appreciation for the openness and honesty displayed by members of AGD's Board of Directors, and especially by the president, Dr. Burton Schwartz. This open communication forms the basis for a very good working relationship between the Academy of General Dentistry and the Certifying Board of General Dentistry.

The Board also wishes to thank AGD for providing the assistance of its staff. Developing and printing application materials, soliciting applicants, evaluating applications, and developing and reviewing written exam questions are just some of the tasks

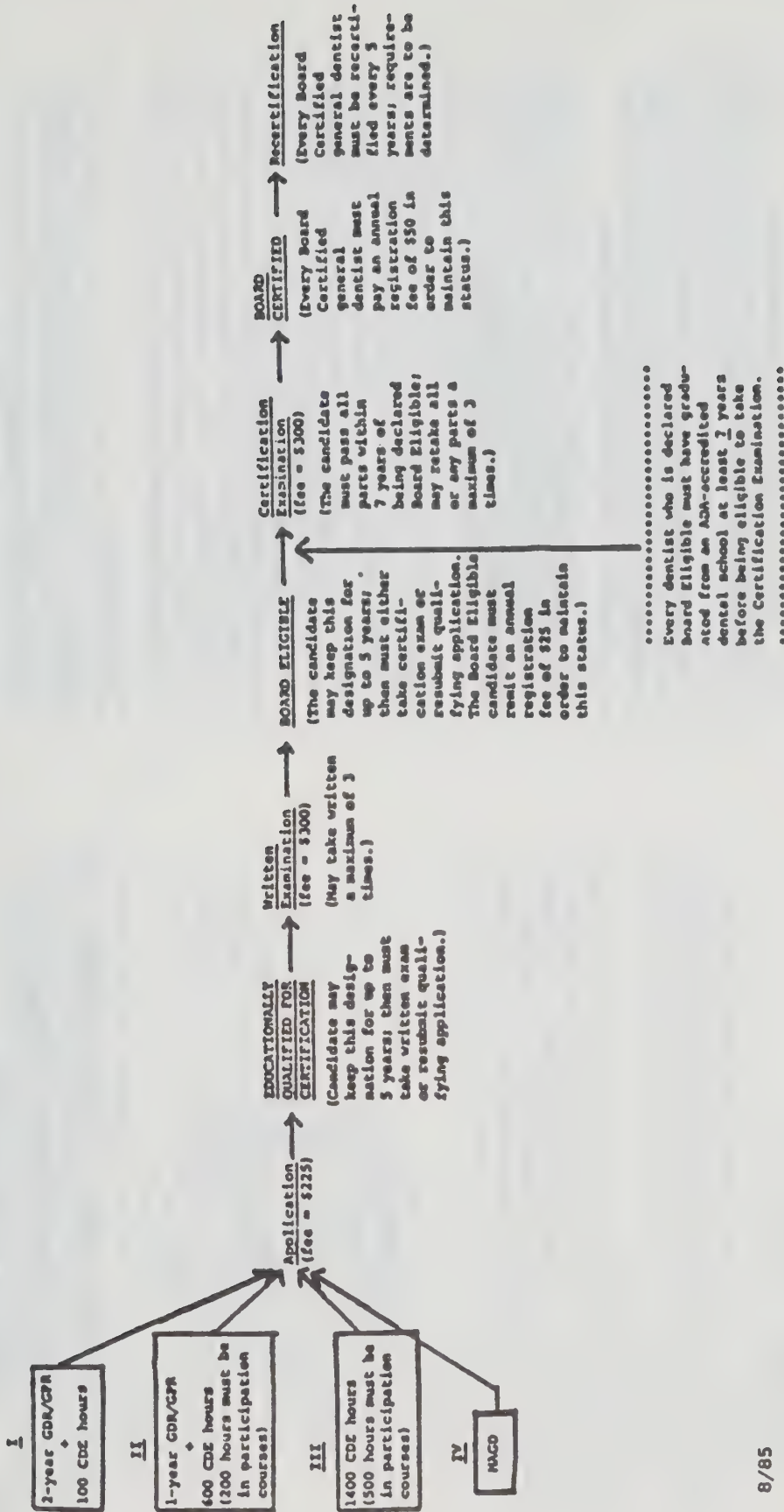
that are made easier and possible in a much shorter time period, because of AGD staff assistance. In addition, the Board is grateful for AGD's donation of photocopying services, meeting space, word processing support, and incidental office supplies. In short, the Board could not have accomplished as much as it has done without AGD's generous assistance. We look forward to a continued positive relationship in the years to come.

Respectfully submitted,

The Certifying Board of General Dentistry

Dan H. Loving, DDS, president
E. Mac Edington, DDS, vice president
J. Frank Collins, DDS, secretary
Clifford H. Miller, DDS, treasurer
George Atkins, DMD
William C. Brokaw, DDS
Howard Bruggers, DDS
Robert B. Mayhew, DMD
Anthony H.L. Tjan, DDS

ROUTE TO CERTIFICATION



8/85

The Certifying Board of General Dentistry

211 East Chicago Ave., Suite 1209
Chicago, IL 60611-2676



Rules and Procedures of the Certifying Board of General Dentistry

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1. BACKGROUND

Organization, Objectives, and Responsibilities

Sponsored by the Academy of General Dentistry, the Certifying Board of General Dentistry was incorporated under the laws of the State of Illinois in 1984 as a not-for-profit organization. No part of its property or earnings shall inure to the benefit of any member thereof.

The Certifying Board was organized to fulfill the following objectives and responsibilities:

1. To elevate the standards and advance the sciences and arts of general dentistry by encouraging its study and advancing its practice;
2. To examine and determine the qualifications and proficiency of dentists who voluntarily apply to the Board for certification;
3. To grant and issue certificates in general dentistry to qualified candidates; and
4. To maintain a registry of all dentists certified and to verify the credentials of those certified upon request.

The Certificate

A certificate conferred by this Certifying Board may be used for credentialing purposes only. Certification does not confer legal qualification, privilege, or license to practice general dentistry. The certificate shall not be held out to the public as evidence of superior skill and/or knowledge. The Board does not intend in any way to interfere with or limit the professional activities of any duly licensed general dentist who is not certified by this Board.

Only one certificate is granted to each successful candidate. Titles to all certificates shall remain the property of the Certifying Board of General Dentistry, but each person to whom a certificate is issued shall be entitled to its possession until it is revoked or voluntarily returned.

Definition of Terms

GENERAL DENTIST: An individual who has successfully completed formal dental training leading to a DDS or DMD degree from a school approved by the Council on Dental Education of the American Dental Association, which qualifies that individual to be licensed to accept the

professional responsibility for the diagnosis, treatment, management, and overall coordination of services that meet a patient's oral health needs, and who has not announced a limitation of practice to any of the specialty areas recognized by the American Dental Association.

CONTINUING DENTAL EDUCATION—Continuing dental education consists of educational activities designed to review existing concepts and techniques and to convey information and knowledge on advances in dental and medical sciences, subsequent to receipt of the basic dental degree.

PARTICIPATION COURSE—A participation course is one in which all course participants actively manipulate dental materials or devices, treat patients, or otherwise practice skills or techniques under the direct supervision of a qualified instructor. The participation activities must represent a significant portion of course content, and they must directly address the major educational objectives of the course.

EDUCATIONALLY QUALIFIED FOR CERTIFICATION—A dentist shall be considered Educationally Qualified for Certification whose filing fee has been paid and whose Qualifying Application and credentials have been approved by the Board. By way of Qualifying Application and supporting documents, the dentist must demonstrate that he or she has met the entry level criteria required by the Board. These criteria are specified in the section of this document labeled *Requirements for Board Certification*. The Board must approve the candidate as Educationally Qualified for Certification before the candidate can be judged eligible to sit for the written examination. The Board confers the status of Educationally Qualified for Certification for a period of five years, during which time the dentist must take and pass the written examination.

BOARD ELIGIBLE—A dentist who is Educationally Qualified for Certification becomes Board Eligible after filing a Written Examination Application and fee and taking and passing the written examination. A dentist designated as Board Eligible must submit case histories in accordance with the guidelines specified in the *Examinations* section of this document within 5 years of notification of the Board Eligible status.

BOARD CERTIFIED—Board Certified status is conferred by the Board on all Board Eligible candidates who pass all parts of the certification examination (specified below in the section titled *Examinations*) within 7 years of being declared Board Eligible.

II. BASIC REQUIREMENTS FOR BOARD CERTIFICATION

A candidate seeking certification by the Certifying Board of General Dentistry must submit all required applications to the Board and successfully pass all examinations given by the Board.

The requirements for eligibility to be examined by the Board are as follows:

- A. Possession of a current license to practice dentistry granted by a dental licensing body with jurisdiction in the United States or Canada;
- B. After graduation from dental school, professional experience and education or training in general dentistry which shall comply with one or more of the following Board-established entry points on the route to certification:

- 1. *Entry Point I*
 - a. Successful completion of a two-year advanced formal educational program in general dentistry which is accredited by the Commission on Dental Accreditation of the American Dental Association or the Canadian Dental Association;
 - b. Documented attendance at a minimum of 100 clock hours of continuing dental education courses. (The criteria for acceptable CDE activities are discussed later in this document.)

2. *Entry Point II*

- a. Successful completion of a one-year advanced formal educational program in general dentistry which is accredited by the Commission on Dental Accreditation of the American Dental Association or the Canadian Dental Association;
- b. Documented attendance at a minimum of 600 clock hours of continuing dental education courses; of the 600 clock hours required, at least 200 must be in participation courses. (The criteria for acceptable CDE activities are discussed later in this document.)

3. *Entry Point III*

- a. Documented attendance at a minimum of 1400 clock hours of continuing dental education courses; of the 1400 clock hours required, at least 500 must be in participation courses. (The criteria for acceptable CDE activities are discussed later in this document.)

4. *Entry Point IV*

- a. Attainment of the status of Master of the Academy of General Dentistry.

III. CRITERIA FOR CONTINUING DENTAL EDUCATION ACTIVITIES ACCEPTED FOR ENTRY INTO THE CERTIFICATION PROCESS

Course Attendance

- 1. All credit hour requirements must be completed prior to the date the Board receives an applicant's Qualifying Application. Credits earned after the completed application is received by the Board may not be applied toward Educationally Qualified for Certification status.
- 2. Courses must be a minimum of one hour in duration.
- 3. Credit must be earned in specific subject categories, as outlined under *Subject Category Requirements*.
- 4. Course content must be directly related to the practice of dentistry.
- 5. Participation course credit is awarded only if a significant portion of the course meets the criteria of a participation course as defined in these Rules and Procedures.

Other Acceptable CDE Activities

- 1. *Teaching*: Teaching is defined as providing a lecture or presentation in an academic setting. Teaching credit may not be used to fulfill any participation course requirements. Teaching credit is not awarded for clinical supervision or table clinics. Teaching hours are awarded for original presentation only. Credit is not awarded for repeats of the same presentation. Credit is awarded to full and part-time teachers who teach in a dental institution (dental school, dental hygiene school, dental assisting school, etc.).

- 2. *Publications*: Credit is awarded if an applicant is an author of a published scientific article or textbook, or chapter in a textbook, as follows:

Textbook, chapter published in a textbook, or article published in a national or international refereed dental journal	65 hours
State dental journal	25 hours
Local dental journal	15 hours

*NOTE: Credit from teaching or publications will be accepted for Entry Points II and III only. Up to 150 hours of the 600 hours required of dentists applying via Entry Point II may be earned by teaching or publication. Up to 350 of the 1400 hours required of Entry Point III applicants may be earned by teaching or publication. These teaching or publication hours can be applied to the minimum CDE requirements only after the minimum hours required for Entry Points II and III are met through actual course attendance. After the minimum number of credit hours are earned in each subject category, teaching and publication credit will be applied to the subject category of the course that was taught or covered in the article or textbook that was published.

Subject Category Requirements

A minimum number of hours must be earned through attendance at courses in each of the 11 dental subject categories as listed below. After these minimums are met, dentists who meet the qualifications for entry via Entry Points II or III may apply credits earned in either actual course attendance, teaching, or publications. The maximum number of hours that will be accepted by the Board is also listed for each subject category. After subject category minimums are met, all dentists may apply credits earned in elective courses.

A. Entry Point I: 100 CDE hours required.

Subject Category	Minimum # of Hours Required	Maximum # of Hours Accepted
Restorative Dentistry	5	20
Periodontics	5	20
Prosthodontics	5	20
Endodontics	5	20
Oral Surgery	5	20
Oral Pathology	5	20
Orthodontics	5	20
Periodontics	5	20
Basic Sciences	5	20
Radiology	5	20
Oral Diagnosis	5	20

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B. Entry Point II: 600 CDE hours required (of which 200 hours must be in participation courses).

Subject Category	Minimum # of Hours Required	Maximum # of Hours Accepted
Restorative Dentistry	30	120
Periodontics	30	120
Prosthodontics	30	120
Endodontics	30	120
Oral Surgery	30	120
Oral Pathology	30	120
Orthodontics	30	120
Periodontics	30	120
Basic Sciences	30	120
Radiology	30	120
Oral Diagnosis	0	150
Teaching/Publications	0	150

C. Entry Point III: 1400 CDE hours required (of which 500 hours must be in participation courses).

Subject Category	Minimum # of Hours Required	Maximum # of Hours Accepted
Restorative Dentistry	70	280
Periodontics	70	280
Prosthodontics	70	280
Endodontics	70	280
Oral Surgery	70	280
Oral Pathology	70	280
Orthodontics	70	280
Periodontics	70	280
Basic Sciences	70	280
Radiology	70	280
Oral Diagnosis	0	350
Teaching/Publications	0	350

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Documentation Required to Substantiate Participation in CDE Activities

The following documentation must accompany each Qualifying Application, in order to substantiate applicant participation in these activities. Documentation must be provided for each CDE course attended, for teaching and publications, and for completion of a QDR or QPR, as specified below:

A. Course Attendance

1. Current AQD course record printouts
2. Current ADA course registry printouts
3. Course record forms
4. CDE registry records from a state recording service
5. Military records of CDE attendance
6. Letters of verification from CDE sponsors or instructors

B. Teaching

A letter from the applicant's supervisor in the institution in which the applicant teaches, verifying the dates of the academic appointment, the subject area(s) taught, and the number of hours spent teaching each subject, is required.

C. Publications

A photocopy of the journal article or frontispiece of the textbook is required.

D. General Dentistry Residency or General Practice Residency

A photocopy of the certificate of completion of the QDR or QPR is required.

E. Mastership in the Academy of General Dentistry

A copy of a letter from the Academy of General Dentistry verifying receipt of the MAQD, or a photocopy of the applicant's MAQD plaque or certificate is required.

IV. APPLICATION PROCEDURES

A. Upon completion of one of the prescribed entry points on the route to certification (as described in the preceding section of this document), candidates may submit a Qualifying Application to the secretary of the Board. Applications must be made on special forms available from the office of the Board.

B. The Qualifying Application form must be accompanied by the following:

1. Documentation of successful completion of all of the requirements outlined in one or more of the entry points on the route to certification; such documentation must conform to the requirements specified by the Board;
2. An application fee payable to the Certifying Board of General Dentistry, in U.S. funds.

All Qualifying Applications must be submitted in English. The fee is not refundable, either in the event of application acceptance or rejection by the Board.

Incomplete applications will not be considered by the Board.

C. The Qualifying Application, along with the necessary documentation and fee, must be sent by registered mail to the secretary of the Certifying Board of General Dentistry, postmarked no later than 8 months prior to the date that the applicant would like to take the written examination.

D. If the Board approves the Qualifying Application and documentation, the applicant will be declared Educationally Qualified for Certification and will be notified of this status by the secretary.

E. Candidates whose applications for Educationally Qualified for Certification status are denied may appeal to the Board. This appeal must be in writing and must be received by the Board within 60 days of the date notification is mailed to the candidate of denial.

F. Approved Qualifying Applications will remain on file with the Board for 5 years after approval. Qualifying Applications of individuals who

do not take and pass the written examination within 5 years after the Qualifying Application was approved will be cancelled. In such cases, neither Qualifying Applications will be returned, nor application fees refunded. A new Qualifying Application and fee will be required of an applicant who fails to take and pass the written examination within 5 years after the date the Qualifying Application was approved. After a new fee is filed and a new Qualifying Application is submitted and approved by the Board, the candidate again is designated Educationally Qualified for Certification for a period of 5 years.

Q. A candidate must submit a completed Written Examination Application and fee to sit for the written examination within 5 years after being designated Educationally Qualified for Certification. Applications for the written examination are available through the office of the secretary. Written Examination Applications must be submitted to the secretary a minimum of 60 days prior to the date that the written examination will be administered.

H. After passing the written examination, a candidate is notified by the office of the secretary of his or her Board Eligible status. A candidate who is Board Eligible must apply to take the certification examination within 5 years after being declared Board Eligible. Every Board Eligible candidate must have graduated from dental school at least 7 years before being eligible to take the certification examination. The Board Eligible candidate must submit a Certification Examination Application no more than 9 months prior to the scheduled date of the candidate's certification examination, and no later than 120 days prior to administration of the candidate's certification examination.

Case histories required for the certification examination must be submitted with the Certification Examination Application. (Criteria for case histories are specified in the section titled *Examinations*.) If the Certification Examination Application, including required case histories, is not submitted within the required 5 years, the candidate is no longer Board Eligible and must reapply to the Board to re-establish the status of Educationally Qualified for Certification, and pass a new written examination within a 5 year period.

I. The office of the secretary will provide candidates with specifications for required case histories, as well as special case history forms at the time that notification is given of Board Eligible status.

J. Candidates may pass parts of the certification examination and fail others. Candidates may be allowed to retake only those parts of the certification examination that were previously failed (see sections titled *Examinations* and *Re-Examinations*). Candidates may retake all or any of the parts failed a maximum of 3 times. If the candidate does not become Board Certified within 7 years after being declared Board Eligible, the candidate is no longer Board Eligible and must reapply to the Board to re-establish the status of Educationally Qualified for Certification, and again pass a new written examination within a 5 year period.

V EXAMINATIONS

The exam program consists of a written examination and certification examination.

All examinations are developed based upon a domain of clinical knowledge, skills, and procedures delineated by the Board and validated by many professionals in the field of general dentistry. The specific contents of this domain can be obtained through the office of the secretary.

Board examinations are criterion-referenced, not norm-referenced. This means that all candidates are evaluated based on the same, pre-established standards of proficiency rather than being compared to the examination performance of other candidates. In determining evaluation criteria and minimally acceptable performance, the Board shall maintain similar standards each year. The Board requires that a candidate pass both the written examination as well as all parts of the certification examination in order to be designated Board Certified.

Examinations shall be administered at a time and place determined by the Board. The Board shall announce the time and place of all examinations at least six months prior to the date of each examination.

A. Written Examination

The written examination is 6 hours in duration and is administered during the course of one day. It contains 400 objective, multiple-choice and clinical simulation problems. The written exam questions are based on a specified domain of general dentistry knowledge, skills, and procedures. The following subjects will be tested:

1. Oral Pathology/Oral Medicine/Oral Diagnosis 56 questions
2. Fixed Prosthodontics 48 questions
3. Periodontics 48 questions
4. Dental Materials 40 questions
5. Endodontics 40 questions
6. Oral Surgery 40 questions
7. Restorative Dentistry 40 questions
8. Removable Prosthodontics 32 questions
9. Dental Radiology 16 questions
10. Orthodontics 16 questions
11. Pedodontics 16 questions
12. Preventive Dentistry 8 questions

A candidate must pass the written examination in order to achieve Board Eligible status and take the certification examination.

A candidate may take the written examination a maximum of three times, regardless of the number of times the status of Educationally Qualified for Certification is conferred. After a candidate fails to pass the written examination a third time, a formal appeal to take the written examination a fourth time must be submitted to the Board.

B. Certification Examination

The certification examination consists of preparation and presentation of case histories, and oral examinations on the case histories and areas of general dentistry not covered in the case history questioning.

1. Case Histories

The case histories section of the certification examination allows the candidate the opportunity to demonstrate clinical abilities in diagnosis, treatment planning, case organization, and documentation.

All cases must conform to the following criteria:

- a. diagnosis and treatment may not have been initiated during any formal residency or advanced education program ever enrolled in by the candidate;
- b. the case must have been performed by the candidate acting as an independent operator;
- c. all documentation required by the Board must be provided, and case history record forms and other pertinent materials supplied by the Board must be used.

The candidate is required to submit three case histories, all at least one year post-treatment.

Candidates must submit case histories that meet specifications to be determined by the Board. Expertise and knowledge of oral diagnosis, oral pathology, oral medicine, oral surgery, endodontics, periodontics, operative dentistry, dental materials, fixed and removable prosthodontics, preventive dentistry, orthodontics and pedodontics must be demonstrated.

The Board requires that the following information be included in each of the case histories submitted:

- 1) A release form, signed and dated by the patient and witnessed;
- 2) Medical and dental history: a synopsis of the patient's past and current medical and dental history pertinent to treatment provided for the case in question;
- 3) Oral examination: the patient's chief complaint, clinical signs and symptoms, and a description of the general dental or oral condition prior to treatment;
- 4) Preoperative complete radiographic survey, including periapical and posterior interproximal views;
- 5) Preoperative color photographs or slides;
- 6) Preoperative diagnostic casts, if indicated;
- 7) Pretreatment diagnosis;
- 8) Treatment plan: a recommended plan of treatment with alternative treatment plans if appropriate;
- 9) Record of clinical procedures and treatment rendered, presented in sequential order;
- 10) Postoperative records: a summary of treatment and/or restorative procedures that followed the primary treatment over a period of not less than one year in duration, including postoperative radiographs and their interpretations, records, color slides, and completed casts where indicated.

Documentation for each case should be typewritten, clear, and precise. Cases should include all models, radiographs, photographs, and any further documentation necessary to substantiate diagnosis and treatment. Copies of radiographs may be submitted, as long as their quality is sufficient to depict the information recorded.

A separate signed form stating "I hereby certify that the diagnosis, planning and essential general dentistry clinical procedures described herein were performed by me as an independent operator" must accompany each case history.

Case histories must meet all Board-established criteria in order to be accepted. If a case history is judged as "conditionally acceptable," it will be returned to the candidate with instructions on corrections and procedures for resubmission.

If a case history is judged as "unacceptable," it will be returned to the candidate. The candidate must submit a new case history to the Board.

Detailed instructions and case history forms are sent from the office of the secretary to the candidate at the time that notification is given of Board Eligible status.

All records, radiographs, casts, photographs and supporting documents for the case histories become the property of The Certifying Board of General Dentistry, and will not be returned to the candidate.

2. Oral Examinations

Oral examinations allow the candidate to defend diagnosis and treatment decisions based on case histories and to apply general knowledge of basic sciences and clinical judgment to general dentistry problems.

There are 2 different oral examinations administered during the certification examination. Each oral examination is conducted by 3 examiners. The candidate is questioned orally in the following situations:

- a. When the candidate submits the three required case histories to the Board, the candidate chooses one on which to be examined. The candidate has 30 minutes to orally present this case to the examiners. The examiners will question the candidate for 90 minutes on the case, including questions over hypothetical situations suggested by the case history.
- b. Another of the three cases submitted by the candidate is chosen by the Board as the basis for oral examination. The candidate will be questioned on this second case for 45 to 60 minutes. The candidate is not informed in advance of the second case that will be selected for oral examination.

c. The second group of examiners will spend 60 to 90 minutes questioning each candidate on general dentistry areas not sufficiently covered in the case histories.

All oral questions and responses are tape recorded and evaluated by the examiners individually and independently, based on prearranged, well-understood, and well-specified criteria.

Irregular Behavior

All examinations are proctored. Giving or obtaining unauthorized information or aid by a candidate, as evidenced by observation, statistical analysis of written answer sheets, or any other irregular behavior, will constitute grounds for invalidation of that candidate's examination. The Board assumes full responsibility for failing candidates on the basis of irregular behavior.

Results of the Examinations

Candidates will be informed of the results of their performance on each of the examinations within eight weeks following administration of the examination.

Results of the examinations will not be released to anyone other than the candidate without the candidate's written consent.

Appeal Mechanism

Candidates who fail the written examination or all or parts of the certification examination may appeal this decision to the Board. Formal appeal procedures are available through the office of the secretary. Each appeal must be submitted in writing and must be received by the Board within thirty days after the examination results are mailed.

Re-Examination

1. Written Examination

Candidates are allowed to take and fail the written examination a maximum of three times, regardless of the number of times that Educationally Qualified status is conferred. Permission to take the written examination a fourth time will be granted only after the candidate submits a formal appeal to the Board and is able to justify an exception to this policy. Formal appeal procedures may be obtained from the office of the secretary.

2. Certification Examination

Candidates will be notified of having passed or failed each part of the certification examination. The candidate may request re-examination only on those parts of the certification examination failed. The candidate must pass all parts of the certification examination within 7 years after being declared Board Eligible in order to be Board Certified.

If the candidate fails Oral Examination on either of the two cases reviewed by the Board, he or she must submit three totally new case histories in accordance with current Board specifications for case histories and must undergo oral examination on two of these cases.

VI. ANNUAL REGISTRATION

A. Board Eligible Dentists

In order to maintain Board Eligible status, the candidate must remit an annual registration fee every year that the candidate does not take and pass the certification examination. If the Board Eligible candidate fails to pay the annual registration fee, the candidate must submit 100 additional hours of CDE and pay the fee in order to reestablish Board Eligible status. The 100 additional hours of CDE must have been taken after the candidate passed the Board's written examination. The hours may be taken in any of the following seven subject categories:

1. Restorative Dentistry
2. Periodontics
3. Prosthodontics
4. Endodontics
5. Oral Surgery, Oral Pathology
6. Orthodontics, Pedodontics
7. Basic Sciences, Radiology, Oral Diagnosis

B. Board Certified Dentists

The Board requires an annual registration fee from each individual designated Board Certified.

Upon payment of the registration fee, a renewal certificate is issued and is valid for one year.

Board Certified general dentists granted retired status by the Board are exempt from an annual registration fee.

An annual roster of active and retired Board Certified general dentists is compiled from this annual registration. A copy of this roster is sent to each Board Certified general dentist, to the Academy of General Dentistry, to the American Dental Association, to the Canadian Dental Association and to the National Dental Association.

VII. RECERTIFICATION

Except for those granted retired status, dentists who have been certified by the Board must be recertified every five years. Requirements for recertification include evidence of continuing education and current credentials and qualifications.

Failure to meet recertification requirements causes the Board Certified general dentist's name to be eliminated from the registration roster. No renewal certificate will be issued, even upon payment of the annual registration fee.

In addition to the annual registration fee, a recertification fee is assessed to cover the expense of reviewing qualifications and administering any recertification examination.

VIII. FEES

Fees paid to the Certifying Board of General Dentistry are not refundable, with the exception of the written examination fee. Dentists canceling before the date of the written examination will receive a refund of \$250. The fees listed below must be paid in U.S. funds and are subject to change without notice.

Qualifying Application Fee	\$225
Written Examination Fee	\$300
Certification Examination Fee	\$300
Re-examination Fees	
1. Written Examination	To be determined
2. Oral Part a (1st Case History)	To be determined
3. Oral Part b (2nd Case History)	To be determined
Recertification Fee	To be determined
Annual Registration Fee	
1. Board Eligible general dentists	\$ 25
2. Board Certified general dentists	\$ 50

IX. REVOCATION OF THE CERTIFICATE

The Board shall have the authority to revoke any certificate issued by the Certifying Board if the dentist holding the certificate:

- A. Has his or her license to practice dentistry revoked;
- B. Is found guilty of any offense which may cause his or her dental license to be revoked;
- C. Makes a misstatement of fact in any application to the Board;
- D. Fails to limit the use of the certificate, as established in Chapter VII, Section 2 of the Bylaws, and as determined by the Board;

E. Fails to pay the annual registration fee prior to or on the deadline established by the Board for receipt of this fee;

F. Fails to meet the recertification requirements of the Board.

Upon revocation of a certificate by the Board, the holder shall return his or her certificate to the secretary of the Board, and his or her name shall be removed from the annual registration roster of Board Certified general dentists.

Hearing and Notice

A. No certificate shall be revoked without giving notice to the dentist whose certification is in question. Written notice of the revocation hearing shall be sent by registered mail to the last known address of the dentist at least thirty (30) days prior to the hearing.

B. The notice shall advise the dentist of the time, date, and place of the hearing, and the grounds for which the Board is considering revocation.

C. The dentist and his or her representative shall be entitled to appear at the hearing. The hearing shall be held at any meeting of the Board.

Jurisdiction of the Board

The Board has sole jurisdiction to determine whether evidence presented is sufficient to reinstate any revoked certificate, and whether any reinstatement requires re-examination.

X. FOR ADDITIONAL INFORMATION

Inquiries regarding this document or any matter pertaining to The Certifying Board of General Dentistry may be forwarded to:

The Certifying Board of General Dentistry
211 East Chicago Avenue
Suite 1200
Chicago, Illinois 60611-2670



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

March 25, 1986

Dr. Dan Loving, President
AGD Certifying Board
211 East Chicago Avenue - Suite 1200
CHICAGO
IL 60611-2670
(U.S.A.)

Dear Dr. Loving:

Thank you for your letter and information sent to me regarding the AGD Certifying Board. As a result of this, and conversations with Drs. Burton Schwartz and Bob Patrick, I will be requesting that our Executive Council and Board table the resolution on our position until we have had more time for discussion.

Dr. Schwartz had suggested that representatives from the organization would be prepared to meet with us. Our Executive Director, Mr. A.J. Neilson, will be in touch with you soon to arrange such a meeting.

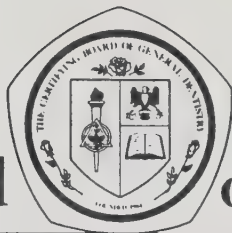
I can offer you no assurances that discussions will change the position but you will have a better opportunity to present your views.

I look forward to meeting with you and your representatives in the near future.

Sincerely yours,

Bradley W. Holmes, D.D.S.
President

/ml



c.c. Executive Council
Brian Henderson

The Certifying Board of General Dentistry

211 East Chicago Ave., Suite 1200, Chicago, IL 60611-2670 (312) 440-4300

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Vice President
J. Frank Collins, DDS
Secretary
Clifford H. Miller, DDS
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William C. Brokaw, DDS
Howard Bruggers, DDS
Robert B. Mayhew, DMD
Anthony H. L. Tjan, DDS

Cynthia M. Costantino
Executive Secretary

February 18, 1986

Dr. Bradley W. Holmes
President
Canadian Dental Association
34 Matheson Street South
Kenora, Ontario P9N 1T6
CANADA

Dear Dr. Holmes:

Dr. W. Robert Patrick, who is a past president of the Academy of General Dentistry and currently affiliated with the Royal College of Dental Surgeons of Ontario, provided me with a copy of a policy statement entitled, "Canadian Dental Association's Position on the Certifying Board of General Dentistry." I am writing to you, Dr. Holmes, in order to promote a better understanding regarding what the Certifying Board of General Dentistry is trying to accomplish. We believe that the Canadian Dental Association may have had some false assumptions when it adopted its policy statement. For example:

1. First paragraph, second and fourth sentences:

"The National Dental Examining Board certificate is recognized for purposes of licensure in all provinces...The need for a separate and distinct certificate is not apparent and could compromise this achievement."

Dr. Holmes, the Certifying Board of General Dentistry was not established to serve as a licensing body. Licensure denotes that a dentist has met competency standards. These standards are most frequently established in order to differentiate dental school graduates with the minimum level of skill and knowledge necessary to practice dentistry from those who could cause harm to a patient because of some knowledge or skill deficit. Licensure is necessary in order to practice general dentistry.

In contrast, a certificate from the Certifying Board of General Dentistry is not considered a prerequisite of general dentistry practice. The Certifying Board of General Dentistry is establishing

Dr. Bradley W. Holmes
February 18, 1986
Page 2

proficiency standards; it was not established to compete with licensing bodies. Assessing proficiency can be compared to assessing the difference between an 'A' and 'B' student: Both are capable, but one is more proficient in the subject matter tested than the other.

2. Third paragraph:

"Preparation of the general dental practitioner remains the primary goal of the undergraduate dental educational programs whose graduates are certified by the National Dental Examining Board in this fashion."

The Certifying Board will be assessing the knowledge and skills of general dentists who have completed extensive formal or continuing post-graduate education programs. Entry into the certification process is not open to recent dental school graduates, as evidenced by the "Basic Requirements for Board Certification" listed on page 3 of the enclosed "Rules and Procedures of the Certifying Board of General Dentistry." (By the way, we believe that this booklet will give you a better understanding of the entire process. Please inform me if your would like additional copies to circulate among your Board members.)

3. Fourth paragraph, first sentence:

"There are a number of groups currently involved with continuing education for general dental practitioners, including the Canadian Dental Association, National Dental Examining Board, and provincial licensing bodies working in cooperation with Canadian faculties of dentistry."

The Certifying Board encourages all continuing dental education sponsors in their efforts to meet "specific needs of individual general dental practitioners concerned with the maintenance of professional competence." The Board is not a continuing education sponsor, so it is not duplicating the efforts of the sponsoring bodies mentioned. In fact, dentists interested in certification will be more likely to attend courses given by these sponsors as they attempt to meet the Board's educational criteria, both for entry into the certification process and for subsequent recertification.

4. Fifth paragraph, first and last sentence:

"The introduction of a Certifying Board of General Dentistry would establish two levels of general practitioners and unnecessarily create disunity in a profession founded on the principle that all dentists must be general practice dentists regardless of additional specialization in specific fields of interest... An additional certificate is not required to attest to the skills, value or worth of the basic general dental practitioner, nor to achieve national portability of general dental practitioners."

Dr. Holmes, Certifying Board members will be the first to admit that board certification will probably appeal to a limited number of general dentists, most likely those who are involved in hospital care, or in academic, administrative or military settings.

I think the most important issue here is "Why Certification?" The present system, in both the United States and Canada, does not offer a way to recognize and objectively document more than the basic level of skill and knowledge in general dentistry. Without such a credential, general dentists will always have difficulty competing with other, board certified, dental professionals for hospital staff, academic faculty, and other positions of leadership in health care. Other general dentists who may not be interested in pursuing leadership positions in the academic or institutional communities may nonetheless choose to become certified to satisfy a personal goal. It is important to note that the certificate is internal to the profession. A board certified general dentist CANNOT inform the public of this attainment, on penalty of revocation of the certificate.

There is a real need for certification of general dentists who are interested in obtaining hospital staff privileges, directorships of advanced formal educational programs in general dentistry, such as general dentistry and general practice residencies, and promotions in academic and military settings. Many general practice residency programs are now being run by specialists rather than general dentists because general dentists do not have the credentials (a certificate from a certifying board) to compete

Dr. Bradley W. Holmes
February 18, 1986
Page 4

with board certified specialists. Specialists have access to a certification process. General dentists do not. This reduces the stature for all general dentists, because it limits the opportunity for advancement of those general dentists who choose to apply for leadership positions.

It is our hope that providing a voluntary, credible certification process for general dentists will ultimately improve undergraduate and especially post-graduate general dentistry training programs, as more general dentists become aware of the certification option, and more general dentists attend both formal and informal continuing dental education programs in an attempt to achieve this goal. Ultimately, perhaps the already high standards of dental patient care will increase.

We sincerely hope that this letter will help to give the Canadian Dental Association a better understanding of what we are trying to accomplish with a certification process for general dentists, and that you will therefore institute the steps necessary to reformulate your policy statement.

Sincerely,



Dan H. Loving, DDS
President

Enclosures: Policy Statement: Canadian Dental
Association's Position on the
Certifying Board of General Dentistry
Route to Certification
Rules and Procedures of the Certifying
Board of General Dentistry

cc: Mr. Jardine Neilson, executive director
Canadian Dental Association
W. Robert Patrick, DDS
Mr. Harold E. Donnell, Jr., executive director
Academy of General Dentistry

cc: Dr. K. Bentley
Dr. A. Schwartz

REVISED DRAFT CDA MISSION STATEMENT

The Canadian Dental Association serves the dental profession -- and through the profession the Canadian public -- as the authoritative national voice and resource for dentists.

In cooperation with the provincial dental associations and affiliated organizations, CDA offers services, in both official languages, intended to support and advise all areas of dentistry and to represent, protect, promote and develop the interests of the dentist as ethical practitioner, professional, educator, student, researcher, business person, citizen and individual.

CDA recognizes a particular responsibility to contribute to the development of national positions and standards related to dentistry, dental education, dental research, dental equipment, dental materials and dental personnel.

CDA is dedicated to the principle that all Canadians should have the best oral health care it is possible to provide; it actively seeks input from and dialogue with governments, consumers and all those interested in dentistry to enable it to serve more effectively both its members and the Canadian public.

July 2, 1986.

STATEMENT RE UNPROVEN TREATMENT METHODS

Treatment methods utilized by dentists in the management of patients which have not been verified by sound scientific evidence should only be used with the patient's informed consent, in writing. This consent would recognize the probabilities of success and the potential complications of such treatment. Such methods of treatment should only be used after other accepted treatment modalities have been assessed and found to be unsuitable.

LOW, MURCHISON

BARRISTERS & SOLICITORS

KENNETH A. MURCHISON, B.COM., Q.C.
D. CAMPBELL BURNS, B.A., LL.B.
JOSEPH W. THOMAS, B.A.
GORDON J. McCAY, B.Sc., LL.B.
JOHN D. PEART, B.Sc., LL.B.
PETER A.J. HARGADON, B.A., LL.B.
DOUGLAS W.J. SMYTH, B.A., LL.B.
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TELEPHONE (613) 236-9442
TELECOPIER (613) 236-7942

April 16th, 1986

A. Jardine Neilson, Esq.,
Executive Director,
Canadian Dental Association,
1815 Alta Vista Drive,
OTTAWA, Ontario.
K1G 3Y6

Dear Sir:

I have received and considered your letter of April 9th, 1986 and the accompanying "Statement re Unproven Treatment Methods".

The statement is probably intended as a helpful guide to practitioners. However, the wording as such is to suggest that this is a recommended or even a required standard of care and conduct and, in my view, the approval and dissemination of this statement to members of the profession could cause them difficulties in the future.

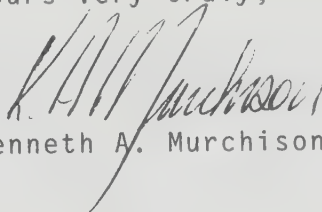
The statement is not accompanied by any guidelines as to what methods have or have not been verified by sound scientific evidence. The statement is, therefore, not helpful to practitioners. In addition, this question would be open to various interpretations and, accordingly, it would be difficult for you or any Provincial association to criticize or reprimand any dentist for an alleged breach of this requirement, since the standard would be entirely subjective.

Of greater concern to me is the possible effect that the statement might have in the event that any claim for negligence was brought on the basis that the procedure adopted by the defendant dentist had "not been verified by sound scientific evidence", in a case where no "written consent" of the patient had been obtained. The existence of this statement would provide counsel for a plaintiff with a very effective opportunity to lead evidence based on this line of argument.

The suggestion that unproven methods could be used, provided the "patient's informed consent" had been obtained, also creates some problems. Obviously, the statement recognizes that any consent given would have to be based on the fact that the patient had been fully informed of the probabilities of success and the potential complications of such treatment. A consent given without full knowledge would not constitute a waiver of a subsequent claim. Presumably, all dentists have a knowledge of what is required in order to obtain an effective consent, including the fact that the patient must have the opportunity to chose between consent and refusal without constraint, compulsion or duress. It is more difficult to determine how a Court would interpret the word "informed". As you are doubtless aware, it is becoming increasingly common in contractual cases for the Courts to require a consent to be based on independent legal advice and, in the case of negligence involving a dentist, it is possible that a Court might expect the dentist to obtain a "second opinion".

For all of these reasons, it is my view that it would be unwise for the Association to issue this statement.

Yours very truly,

A handwritten signature in dark ink, appearing to read "K. A. Murchison". The signature is fluid and cursive, with the first name "K" being particularly large and stylized.

Kenneth A. Murchison, Q.C.

KAM:d1



625, boul. Dorchester ouest, 5e étage - Montréal, QC H3B 1R2 (514) 875-8511

April 18, 1986

Dr. Bradley W. Holmes
President
Canadian Dental Association
1815, Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Bradley:

I am writing to you today pertaining to the present and future relationship between the Ordre des dentistes du Québec and the Canadian Dental Association.

It is quite apparent that when one looks at the various Councils at the CDA, such as, Dental Materials and Devices, Education and Accreditation (Undergraduate, Graduate/Postgraduate Committee, Auxiliaries Committee, Dental Admissions Test Committee, Continuing Education Committee), Ethics, Health Care (Public Health and Preventive Dentistry Committee, Dental Auxiliaries Committee, Executive Committee on Health Care), Hospital and Institutional Services, and Information Services, that these Councils are directly related to similar committees and activities under the jurisdiction of the Ordre des dentistes du Québec.

In the other remaining areas such as the Council on Insurance and Investment and the Taxation Committee, although they are more oriented towards the QDSA, the Order is implicated in some circumstances, especially since one must have malpractice insurance coverage as a condition of licensure in Quebec.

When one then looks at the overall budget of the Canadian Dental Association it is quite apparent that the dollars spent are again mostly directed to similar committees and activities under the jurisdiction of the Order, for besides the Councils, the CDA Journal and the CDA Annual Convention one can also take into account a corresponding proportion of administrative expenses relative to the running of CDA Headquarters and the activities of the Executive Council and Board of Governors.

...2

April 18, 1986

Dr. Bradley W. Holmes
President
Canadian Dental Association

page 2

When the present Executive Committee at the Ordre des dentistes du Québec established its priorities, one of these was the establishment of a direct relationship with the Canadian Dental Association and we are now actively concerned with this subject matter having dealt with most of the other items which required our immediate attention.

The members of the Board of Governors of the Ordre des dentistes du Québec requested that I as President relate their feelings to you which I did verbally in Ottawa on Thursday, April 3, 1986. As per your request and as a result of the above, I have also put our thoughts in writing in order to summarize the wishes of our Board from our January 31, 1986 meeting. The members requested that:

- 1) the ODQ receive a copy of all CDA Accreditation Reports related to Quebec;
- 2) the ODQ have representation on all CDA Councils whose mandates fall under the jurisdiction of the ODQ; and
- 3) the necessary steps be taken to permit the ODQ to have representation as a voting member of the CDA Board of Governors.

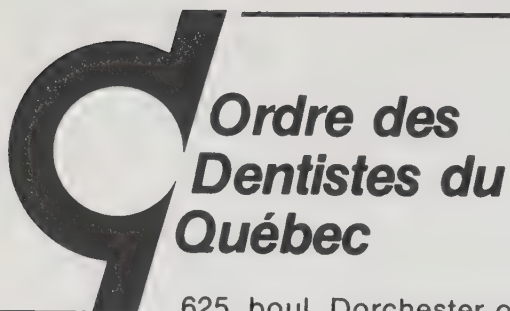
We look forward to a positive response to our request from the members of your Executive Committee in the best interests of everyone concerned.

Yours truly,

Marc Boucher

Marc BOUCHER, D.D.S.
President

MB/ce



625, boul. Dorchester ouest, 5e étage - Montréal, QC H3B 1R2 (514) 875-8511

June 24, 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815, Alta Vista Drive
OTTAWA (Ontario)
K1G 3Y6

Dear Jardine,

I am writing to you in the same vein as our most recent letter to you pertaining to our continued relationship and representation from the Ordre des dentistes du Québec at all levels of the Canadian Dental Association.

On behalf of the Executive and Board of the Ordre des dentistes du Québec, I would like to, therefore, nominate Dr. Clyde Covit as a candidate from Québec to the CDA Council on Information Services.

The mandate of your Council on Information Services falls under the jurisdiction of the Ordre des dentistes du Québec, and seeing that we are very active in this domain, we feel it would be beneficial to everyone concerned if the Chairman of our Communications Committee be the representative to the CDA Council on Information Services.

It goes without saying that the relationship between both parties will, of course, be enhanced by an individual who is completely knowledgeable, aware of what is happening in Québec, and able to speak on behalf of the dentists in this province in matters pertaining to Information Services.

Your immediate attention to our request will be truly appreciated.

Yours truly,

PYL/amc

Pierre-Yves Lamarche, d.d.s., m.a.h.
Executive Director

The CDA Five Year Financial Forecast

A long range plan is an important tool in the management of any organization. It allows you to think ahead. Part of any long term plan of course is a long-term financial forecast. It is an attempt to attach a dollar amount to the various project areas you have charted.

The CDA's five year financial forecast as presented here, is strictly a factored projection of the '87 budget. That is to say, we have taken the '87 budget as presented, and factored in a 4 percent increase in each year for the next four years. It assumes no changes to the program.

As one might well imagine, this is not a very realistic or practical approach to long range planning. Nonetheless, it serves a useful purpose. It shows the direction of the CDA and our intention to maintain a balanced budget.

	1986 Budget	1987 Budget	1988 Projection	1989 Projection	1990 Projection	1991 Projection
EXPENSES						
EXECUTIVE						
Staff	\$160,700	\$220,267	\$229,078	\$238,241	\$247,770	\$257,681
Management Committee	134,232	139,433	145,010	150,811	156,843	163,117
Executive Council	68,908	66,142	68,788	71,539	74,401	77,377
Executive Council Liaison	25,124	25,100	26,104	27,148	28,234	29,363
President	66,200	66,550	69,212	71,980	74,860	77,854
Taxation	7,878	3,057	3,179	3,305	3,439	3,576
Constitution & By-laws	8,060	4,286	4,457	4,636	4,821	5,014
Ethics	4,680	5,968	6,207	6,455	6,713	6,982
Nominations	2,626	1,500	1,560	1,622	1,687	1,755
Salaried Dentists	4,368	4,557	4,843	5,037	5,236	5,448
Government Relations	26,408	2,500	2,500	2,704	2,812	2,925
Board of Governors	99,824	83,925	87,282	90,773	94,404	98,180
Specialty Sections	6,500	6,255	6,505	6,765	7,036	7,317
Physicians & CEOs	11,102	9,738	10,128	10,533	10,954	11,392
FDI Congress	20,500	20,000	20,800	21,632	22,497	23,397
Legal	20,000	20,000	20,800	21,632	22,497	23,397
Grants	11,000	13,000	13,520	14,061	14,623	15,208
Awards	0	4,500	4,680	4,867	5,062	5,264
Other	35,190	30,457	31,675	32,942	34,260	35,630
Unbudgeted Projects	30,000	20,000	20,800	21,632	22,497	23,397
Total	\$742,300	\$747,335	\$777,228	\$808,318	\$840,650	\$874,276
ADMINISTRATION						
Staff	\$324,879	\$215,326	\$223,939	\$232,897	\$242,212	\$251,901
Operations	260,910	245,565	253,388	263,603	276,227	287,276
Membership	57,828	67,567	70,270	73,080	76,004	79,044
FDI Admin	20,000	20,000	20,800	21,632	22,497	23,397
Equipment	41,000	41,000	42,640	44,346	46,119	47,964
Data Processing	39,000	43,000	44,720	46,509	48,369	50,304
Property	283,550	282,430	293,748	305,498	317,718	330,427
Total	\$997,167	\$914,908	\$951,504	\$989,564	\$1,029,147	\$1,070,313
ACCREDITATION						
Staff	\$100,512	\$136,188	\$141,636	\$147,301	\$153,193	\$159,321
Third Party Plans	22,118	36,767	38,238	39,767	41,338	43,012
Education & Accreditation	46,156	72,774	75,685	78,712	81,861	85,135
School Surveys	81,900	62,770	65,281	67,892	70,608	73,432
Health Care	19,826	18,416	19,153	19,919	20,715	21,544
Hospital Services	33,870	20,685	21,512	22,373	23,268	24,199
Hospital Surveys	8,280	12,525	13,026	13,547	14,089	14,652
Dental Materials & Devices	17,554	15,797	16,429	17,086	17,769	18,480
Total	\$330,216	\$375,922	\$390,959	\$406,597	\$422,861	\$439,776
EDUCATIONAL SERVICES						
Staff	\$190,460	\$247,995	\$257,915	\$268,231	\$278,961	\$290,119
Product Recognition	14,586	15,552	16,278	16,929	17,605	18,311
Library	15,515	18,500	18,240	20,910	20,810	21,642
Student Affairs	59,418	77,506	83,152	89,718	96,347	103,040
Information Services	378,168	115,236	119,866	124,661	129,647	134,833
Conferences	22,500	360,643	375,069	390,071	405,674	421,901
Total	\$805,247	\$813,692	\$846,240	\$880,089	\$915,293	\$951,905
JOURNAL						
Staff	\$128,448	\$148,184	\$154,111	\$160,276	\$166,687	\$173,354
Editorial Board	7,124.00	7,598.00	7,901.92	8,218.00	8,546.72	8,884.59
Journal Production	391,320.00	452,646.00	470,751.84	489,581.91	509,165.19	529,531.80
Journal Sales	99,300.00	91,130.00	94,775.20	98,566.21	102,508.86	106,609.21
Total	\$622,192	\$689,558	\$727,540	\$755,642	\$786,908	\$818,384
TOTAL EXPENSES	\$3,497,122	\$3,551,415	\$3,693,472	\$3,841,210	\$3,994,859	\$4,154,653
NFT SURPLUS/(DEFICIT)	(\$312,976)	\$4,589	\$13,217	\$13,746	\$14,161	\$14,727

CDA FIVE YEAR PLAN 1986 - 1991

REVENUE	1986 Budget	1987 Budget	1988 Projection	1989 Projection	1990 Projection	1991 Projection
MEMBERSHIP FEES						
Active	\$1,952,964	\$2,160,726	\$2,247,155	\$2,337,041	\$2,430,523	\$2,527,744
Corporate	82,520	103,150	107,276	111,567	116,030	120,671
Affiliate	0	5,200	5,408	5,624	5,849	6,083
Supporting	10,080	10,500	10,920	11,357	11,811	12,284
Student	25,805	30,400	31,616	32,881	34,196	35,564
Total	\$2,071,369	\$2,309,976	\$2,402,375	\$2,498,470	\$2,598,409	\$2,702,345
ACCREDITATION						
Survey Revenue	\$33,200	\$33,175	\$34,502	\$35,882	\$37,317	\$38,810
Grants - NDEB	15,000	15,000	15,600	16,224	16,873	17,548
Grants - Transfer of Corporate	62,175	124,350	129,324	134,497	139,877	145,472
Total	\$110,375	\$172,525	\$179,426	\$186,503	\$194,067	\$201,830
EDUCATION						
DAT Revenue	\$140,000	\$150,000	\$155,000	\$162,240	\$168,730	\$175,479
Grants - Student Affairs	15,000	15,000	15,600	16,224	16,873	17,548
Total	\$155,000	\$165,000	\$171,600	\$178,464	\$185,603	\$193,027
COMMUNICATIONS						
NDHM Revenue	\$20,000	\$33,000	\$34,320	\$35,693	\$37,121	\$38,605
Product Recognition	24,000	24,000	24,960	25,958	26,997	28,077
Publications	75,000	80,000	83,200	86,528	89,989	93,589
Convention	3,120	(5,000)	3,245	3,375	3,510	3,650
Total	\$122,120	\$132,000	\$145,725	\$151,554	\$157,481	\$163,780
JOURNAL						
Advertising	\$430,000	\$490,800	\$510,432	\$530,849	\$552,083	\$574,167
Subscriptions	16,000	16,000	16,640	17,305	17,998	18,718
Other income	5,000	1,500	1,560	1,622	1,687	1,755
Total	\$451,000	\$508,300	\$528,632	\$549,777	\$571,768	\$594,639
OTHER						
Interest	\$90,000	\$90,000	\$93,600	\$97,344	\$101,238	\$105,287
Rental income	178,282	172,203	179,091	186,255	193,705	201,453
FDI Recipients	6,000	6,000	6,240	6,490	6,749	7,019
Other income	0	0	0	0	0	0
Total	\$274,282	\$268,203	\$278,931	\$290,088	\$301,692	\$313,760
TOTAL REVENUE	\$3,184,146	\$3,556,004	\$3,706,689	\$3,854,957	\$4,009,020	\$4,169,381

PROPERTY MANAGEMENTReport on Leasing Status as of July, 1986

All available rental space in the CDA building has been let with the exception of 1,013 sq. ft. on the first floor.

Below is a breakdown of tenant occupancy:

<u>SPACE</u>	<u>RATE</u>	<u>TERM</u>
<u>Society for Educational Visits & Exchanges in Canada</u>		
4,008 sq.ft.	\$15.00/sq.ft	3 years ending June 26, 1989
<u>Canadian Council on Hospital Accreditation</u>		
3,796 sq.ft.	\$14.21/sq.ft	5 years ending November 30, 1989
<u>Red Cross</u>		
2,789 sq.ft.	\$14.67/sq.ft	2 years ending July 31, 1987
<u>Federation of Medical Women in Canada</u>		
165 sq.ft.	\$14.00/sq.ft	3 years ending December 31, 1988
<u>Clendenning</u>		
210 sq.ft.	\$12.00/sq.ft.	2 years ending November 30, 1986
<u>Ottawa Dental Society</u>		
Approx.:	70 sq.ft.	\$75.00 per month

1.

FDI NATIONAL TREASURER

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS1. FDI - World Dental Congress - Vancouver, B.C.

(a) Site Visit - February 25-28, 1986

Dr. Jan Erik Ahlberg, FDI Executive Director, and Miss Mary Barker, FDI Assistant Executive Director performed the official FDI site visit in Vancouver on February 25-28, 1986 in response to CDA's proposal to hold the FDI World Dental Congress in Canada on August 22-28, 1993.

The CDA and the College of Dental Surgeons of B.C. arranged an agenda which included a city tour of Vancouver, a VIP tour of the Expo '86 site, visitations to the major hotel properties, an extensive tour of the convention facilities, a meeting with the senior representative of the major Vancouver hotels, and a variety of social functions hosted by the local tourist industry. Miss Linda Teteruck was responsible for the glorious sunny weather that complemented the site visit.

At the conclusion of the formal visit requirements, a meeting was held with the FDI officials to review and discuss their findings. Dr. Ahlberg and Miss Barker reported that Vancouver was an excellent venue for a successful congress that would be attractive to the international community. Dr. Ahlberg stated that he was impressed with the associations' staff support, both nationally and provincially, who would be responsible for a major portion of the organization of the meeting. Both he and Miss Barker were confident that the new Vancouver Trade and Convention Centre, with its adjacent Pan-Pacific Vancouver Hotel, and surrounding Vancouver hotels could well accommodate FDI's needs.

FDI NATIONAL TREASURER

Discussion then centred on two major points:

i. Local Hotel Policy

- FDI will require that local hotels will not offer lower hotel rates to tour groups than the rate established as the "Congress rate".
- FDI will require approximately 70 rooms and suites for FDI VIPs.

Mr. Steve Halliday, General Manager of the Pan-Pacific Vancouver Hotel and Chairman of the Vancouver Hotel Consortium has since confirmed these two items with Dr. Ahlberg.

ii. Dates of the FDI Congress

- Sweden has requested that 1993 be assigned to Gothenburg, Sweden since it is celebrating its centenary as a Dental Association.
- The late August date suggested by CDA may be a problem since school children are still on vacation and FDI World Congress events are not usually family affairs. FDI would prefer a late September or early October date.

The CDA responded by stating that Canada would be receptive to any request by Sweden to move our proposal to 1994. In addition, the Vancouver Trade and Convention Centre would be approached in order to secure the preferred dates.

Dr. Ahlberg concluded the meeting by stating that he would recommend to his Executive that Vancouver, B.C. be accepted as a site for the FDI World Dental Congress.

(b) Executive Meeting - London, England

On February 12-13, 1986, the Executive of the FDI met in London, England and on their agenda were proposals to host the FDI World Dental Congress in 1993 from Canada and Sweden.

The Canadian proposal included an offer to give serious consideration to any requests from Sweden to move the Canadian proposal to 1994. In addition, dates in late September - early October were available in Vancouver, B.C. for both 1993 and 1994.

FDI NATIONAL TREASURER

Dr. Ahlberg contacted the FDI National Treasurer - Canada shortly after the Executive Meeting to inform him that the FDI Executive had recommended Sweden as the site for the 1993 FDI meeting and Vancouver, Canada as the site for the 1994 meeting in the fall (i.e. October 2-8, 1994).

The Executive's report and recommendations will be forwarded to the Council of the FDI who will further make recommendations to the General Assembly of the FDI in Manila, November 9-14, 1986.

2. 1986 FDI World Dental Congress - Manila

Late in 1985, serious concern existed as to whether the 1986 FDI meeting would take place in Manila. The FDI Executive Director made a site visit to Manila in December, 1985 and had many communications with the Philippine Dental Association early in 1986. In March, 1986, Dr. Ahlberg and the Philippine Dental Association issued a release which confirmed the 1986 Manila FDI meeting and further provided support and encouragement from Philippine President Corazon Aquino for the world dental community to attend the FDI meeting in Manila.

The CDA has provided advertisements in the CDA Journal and has provided a mailing to all previous FDI members soliciting FDI membership and providing information on the Manila meeting. Additional membership solicitation and congress information will be included in the next CDA general mailing.

Respectfully submitted,



Robert N. Hicks, D.D.S., M.S.
National Treasurer - Canada

ADOPTION OF REPORT

The Board of Governors accepts the FDI National Treasurer's report with appreciation.



c.c. Executive Council
Dr. Hicks
W. Thompson
K. Croft

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

April 25, 1986

Federation Dentaire Internationale
c/o Dr. J.E. Ahlberg, Executive Director
64 Wimpole Street
LONDON
W1M 8AL
(U.K.)

Dear Sirs:

RE: FDI Congress - 1993
Vancouver, B.C. - Canada
Canadian Dental Association

This letter is a formal request and proposal for the 1993 FDI World Dental Congress to be held in Canada within the city of Vancouver, British Columbia. This proposal is presented and sponsored by the Canadian Dental Association.

The enclosed document, with its supporting information and photographs, clearly establishes the capability of the City of Vancouver and the Canadian Dental Association to meet the requirements of the FDI for hosting a World Congress activity. In addition, the Canadian Dental Association and the College of Dental Surgeons of British Columbia, (the Host Provincial Association), have professional, trained convention organizers on their staffs. These are skilled and experienced personnel, capable of organizing an event of this scope.

Dr. J.E. Ahlberg and Ms Mary Barker visited Vancouver in February of this year, and carried out an on-site inspection. Following the visit, their report to the CDA Executive Meeting was most supportive of Vancouver as an FDI World Congress location.

The dates originally proposed for the Vancouver FDI Congress were August 22-28, 1993. In the site inspection report of Dr. Ahlberg and Ms Barker, concern was raised about Congress dates in late August. Following their departure, our Association was able to provide alternate dates of September 26 - October 2, 1993.

.../2

Recently, our Association received a letter from Dr. Runo Cronström, President, Swedish Dental Association, identifying an interest in arranging an FDI Congress in Sweden in 1993. The Canadian Dental Association has investigated alternate dates for an FDI Congress in Vancouver, and would be able to give serious consideration to hosting this event August 21-27 or October 2-8 in 1994. Unfortunately, the 1992 date suggested in a letter sent by Dr. Cronström to Dr. Sebastian, President of the Bundesverband der Deutschen Zahnärzte, is not a possible alternative for the Canadian Dental Association.

As you are aware, the Canadian Dental Association was preparing a proposal to host an FDI Congress for the year 1991. After discussions held during the Tokyo Congress, Canada moved its planning objective to 1993 on the recommendation of your Executive, in order to accommodate a proposal from Italy. While we will give serious consideration to the Swedish proposal to move out of 1993, you must appreciate our concern of "wearing our welcome thin" with the convention industry in Vancouver, if we cannot confirm a date at World Congress 1986, Manila.

It is most important that the Canadian Dental Association receive a firm response to this proposal at the FDI World Dental Congress in Manila. The new world class convention site in Vancouver is rapidly being booked, and many years in advance.

We look forward to your full endorsement and support of our proposal.

Sincerely yours,


A. Jardine Neilson
Executive Director

/ml



FEDERATION DENTAIRE INTERNATIONALE
INTERNATIONAL DENTAL FEDERATION

ASSOCIATION DENTAIRE MONDIALE A BUT SCIENTIFIQUE
IN COLLABORATION WITH THE WORLD HEALTH ORGANISATION

HEADQUARTERS OFFICE
64 WIMPOLE STREET
LONDON, W1M 8AL U.K.
TELGRAM: INDENFED LONDON, W. 1.
TELEPHONE: 01-935 7852
01-487 4544

CAN/1

3 June 1986

C.C.: Dr. R.N. Hicks
Dr. W.R. Thompson
Mr. Ken Croft

Mr A Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa
Ontario
K1G 3Y6
Canada

Dear Mr Neilson,

I am pleased to confirm that the Executive Committee of the FDI discussed the invitation of the Canadian Dental Association to host the Federation's Annual World Dental Congress in 1993 or 1994 during their meeting in London 12-14 May.

The Executive Committee decided firmly to recommend to the Council and the General Assembly to accept the invitation to arrange the Congress in Vancouver, subject to the following provisos.

Please find appended a statement from the Executive Committee regarding further clarifications regarding the hotel situation in the host city and related matters which the Executive Committee has felt forced to issue in relation to every invitation that has not been finally accepted by the General Assembly, in other words for years after 1989.

I hope that it shall not meet with any problems to provide the requested confirmations prior to the 1st of September 1986 then the Executive Committee will have to start preparing its final recommendations to the Council in Manila.

The Executive considered at the same time the invitation from the Swedish Dental Association to host the Annual World Dental Congress in 1993 and the discussions that they have taken up with your Association in this respect. On the assumption that your Association would be prepared to come to an agreement with the Swedish Dental Association, the Executive Committee would be pleased to recommend 1994 as the year for the Annual World Dental Congress in Vancouver.

Yours sincerely

Dr J E Ahlberg
Executive Director

cc Executive Committee, Swedish Dental Association

CERTAIN CONDITIONS FOR ACCEPTANCE OF INVITATIONS TO HOST
ANNUAL WORLD DENTAL CONGRESSES

The Executive Committee noted that considerable unforeseen work in the FDI Headquarters Office and Central Registration Secretariat has arisen and understandable frustration has been expressed in recent years among some member associations, exhibitors and travel agencies in connection with the allocation of hotel rooms and the establishment of hotel rates. Among various measures aimed at increasing the attractiveness of the Congress, it was a top priority to eliminate the reasons for such dissatisfaction as far as possible. This could only be done prior to final acceptance of a Congress venue and before disclosure of the dates for the Congress.

The Executive decided therefore, in respect of invitations for years after 1989, to request each inviting organisation to confirm in writing prior to 1st September 1986:

- 1 the number of hotel rooms, double and single, in figures and as a percentage of total capacity, for each hotel intended to house congress participants and confirmed by the hotel in writing to the Association;
- 2 confirmation of the rates to be applied during the Congress as a percentage of the individual rates/rack rates at the time of the Congress for congress participants;
- 3 an undertaking from the hotels not to contract room allocations directly with travel agencies for the period of the Congress for Congress participants without the express consent of the FDI.
- 4 In context of the above negotiations with hotels and with reference to section 5.3 of the Memorandum on Annual World Dental Congresses, agreements should also be reached with the hotels to obtain complimentary hotel rooms in sufficient numbers to meet with the needs of the members of the FDI Council, Commission Officers, staff and invited speakers (approximately 500 bednights) to minimise the obligations of the inviting association.
- 5 Finally, the Executive Committee decided to request confirmation in writing from the inviting association that discussions with the airline(s) to be appointed official carrier(s) had provided an assurance that air transport of FDI Council, Commission Officers, staff and invited speakers would be available on their scheduled routes at no cost to the FDI.
- 6 It should be noted that any specific dates proposed for the Congress during the year must be kept strictly confidential until the FDI confirms that the conditions under 4 and 5 above have been satisfactorily met in order to prevent some travel agencies making individual agreements with hotels about room allocations and rates to the detriment of a fair supply of hotel rooms for all participants.

In all other respects the rules laid down in the Memorandum will remain applicable.



FEDERATION DENTAIRE INTERNATIONALE
INTERNATIONAL DENTAL FEDERATION

ASSOCIATION DENTAIRE MONDIALE A BUT SCIENTIFIQUE
IN COLLABORATION WITH THE WORLD HEALTH ORGANISATION

HEADQUARTERS OFFICE
64 WIMPOLE STREET
LONDON, W1M 8AL U.K.
TELGRAM: INDENFED LONDON, W. I.
TELEPHONE: 01-935 7852
01-487 4544

CAN/1

4 June 1986

Mr Steve Halliday
General Manager
Pan Pacific Vancouver Hotel
300-999 Canada Place
Vancouver
British Columbia
Canada
V6C 3B5

Dear Mr Halliday,

Thank you for your letter of May 1, concerning the Federation's Annual World Dental Congress.

In the meantime, since our visit to Vancouver, discussions have taken place between the Swedish Dental Association and the Canadian Dental Association concerning the possibility of Sweden hosting the Congress in 1993. I understand that the Canadian Dental Association takes a positive attitude to this request.

The Executive Committee of the FDI decided therefore, during their meeting, 12-14 May, to confirm that they will recommend Vancouver as a congress venue but primarily for 1994.

The Executive Committee appreciated your assurances regarding the hotel situation. Due to our experiences of the problems related to this in later years, the Committee decided as a matter of principle to issue the enclosed statement to all Associations, offering to host FDI congresses in the future. I understand that Dr Robert Hicks will be in contact with you about this and Mr Michael Davis may also have an opportunity to talk this over with my Assistant Executive Director, Miss Mary Barker, during his stay here in London. I will, unfortunately, be in Switzerland on duty travel.

Our Committee appreciated greatly Miss Barker's and my report regarding the positive response that we had received in Vancouver from yourself and other hoteliers.

Yours sincerely

Dr J E Ahlberg
Executive Director

578

cc Dr Robert Hicks, Mr Jardine Neilson, Executive Committee

CAN/1

Pan Pacific Vancouver

May 01, 1986

Dr. J.E. Ahlberg,
Executive Director,
FEDERATION DENTAIRE INTERNATIONALE,
64 Wimpole Street,
London, W1M 8AL,
United Kingdom

Dear Dr. Ahlberg:

**Re: Federation Dentaire Internationale
August 22 - 28, 1993**

Further to our previous discussions relative to the Federation Dentaire Internationale, the six major downtown hotels listed below, including the Pan Pacific Vancouver Hotel, are able to offer you the alternative dates of September 26 - October 02, 1993.

Should you choose and have Board Approval for these alternative dates, this letter will confirm, on behalf of all properties concerned, that we will extend the maximum room block normally extended to a group at that time of the year, including maximum suite commitment.

Each property will be responsible for confirmation directly to you, prior to your definite commitment to hold this congress in the City of Vancouver in 1993.

It is understood that all hotels will protect their full blocks for the Federation Dentaire Internationale only, and that no other arrangements will be made for tour groups, or other outside parties, who indicate that they have Federation Internationale members wishing to block space. We do, however, reserve the right to confirm other business which is not identified or connected with the Federation Dentaire Internationale.

All inquiries for same will be directed to the local organization committee for room and suite allocations.

...../2

Dr. J.E. Ahlberg

- 2 -

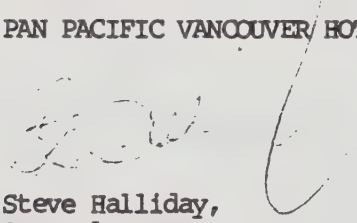
May 01, 1986

Each hotel will be responsible for providing their own terms and conditions as they relate to that hotel, i.e., deposit policies, reservation cancellation policies, rates, etc.

We look forward to welcoming the Federation Dentaire Internationale in 1993. The best of service awaits you.

Sincerely,

PAN PACIFIC VANCOUVER HOTEL,



Steve Halliday,
General Manager.

SH/klg

cc: Denis Forristal, General Manager, Westin Bayshore
Jetsa Pottinga, General Manager, Holiday Inn Harbourside
Doug Forseth, General Manager, Hyatt Regency Hotel
Michael Lambert, General Manager, Hotel Vancouver
Jacques Ferriere, General Manager, Hotel Meridien
Ruy Paes-Braga, General Manager, Four Seasons
Michael Davis, General Manager, B.C. Convention Centre
Art Jones, General Manager, Greater Vancouver Convention and
Visitors Bureau

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Council Members: Dr. R.Y. Barolet, Chairman, Quebec
Dr. W.B. Chapple, Ontario
Dr. M. Eggert, Alberta
Dr. G. Nikiforuk, Ontario
Dr. J. Speck, Ontario
Dr. W.C. Sturtridge, Ontario

Observer: Dr. T. Dubas, Health Protection Branch, Health & Welfare
Canada

1. Committee Meetings

The committee has met twice since the last report to the Board, on February 17, 1986 and on June 2, 1986.

Items for Information - Not Requiring Board Action2. Mentadent-P Toothpaste

The Committee was requested by Lever Brothers to review the advertising guidelines it had imposed on promotion of Mentadent-P toothpaste in light of its recent approval by HPB as both an anti caries and anti plaque dentifrice. Zinc Citrate was regarded by HPB to be an effective chemical agent for the removal of supragingival plaque.

The Committee agreed to allow advertising for Mentadent-P as an anti-caries/anti-plaque agent provided that:

- (1) any anti plaque claims would refer to supragingival plaque only
- (2) there would be no reference to the maintenance of healthy gums through use of Mentadent-P
- (3) that CDA's Seal of Recognition be positioned such that there can be no association with any anti plaque claims
- (4) that regular dental visits be stressed in order to maintain good oral hygiene.

The Committee will continue to closely monitor all advertising related to Mentadent-P.

COMMITTEE FOR CONSUMER PRODUCTS RECOGNITION

3. Gibbs and Mentadent Toothbrush Ads

As mentioned in our last report to the Board, Lever Brothers had published a toothbrush ad stating that CDA has approved a particular toothbrush design. Following discussion with Lever Brothers, CDA has been informed that this professional ad has been withdrawn.

4. Update - Anti Plaque Guidelines

The Committee continues with its review and development of guidelines for plaque removal as this applies to dentifrices and mouth rinses. Input has been requested from each Canadian dental faculty, the Canadian Academy of Periodontology and a number of leading Canadian periodontists. Under the direction of Dr. Michael Eggert, from the University of Alberta, draft guidelines will be developed and reviewed at our September 1986 meeting.

5. Review of Comparative Advertising Guidelines

The Committee has reviewed its position on comparative advertising and has decided to maintain its position on the non acceptance of any type of comparative advertising. It was recently brought to the Committee's attention that Health Protection Branch allows comparative advertising for cosmetic claims. CDA has decided not to follow HPB's direction in this area.

6. Guidelines for Corporate Presentations

The Committee feels it is important to provide corporations with the opportunity to meet with them to discuss areas directly pertaining to the Recognition Program and the Committee's mandate. A set time period has been allowed at each meeting with any one company allowed one half hour to present and discuss an issue. Requests will be granted on a first come basis and all Seal of Recognition holders have been invited to participate.

7. Committee Membership

The Committee is pleased to welcome Dr. Michael Eggert as a member. We feel his expertise, particularly in the area of periodontal disease will add greatly to Committee productivity.

Respectfully submitted,

Ralph Y. Barolet, DDS, MSD
Chairman
Consumer Products Recognition

ADOPTION OF REPORT

The Board of Governors accepts the report of the Committee for Consumer Products Recognition with appreciation.

MEMBERSHIP COMMITTEE

REPORT TO THE 1986 INTERIM CDA BOARD OF GOVERNORS

Members: Dr. Ralph Crawford, Chairman, Winnipeg, Manitoba
Dr. Bradley Holmes, CDA President, Kenora, Ontario
Dr. Ed Busvek, St. Thomas, Ontario
Dr. Gilles Dubé, Lachute, Québec
Dr. Rita Hurley, Montreal, Quebec
Dr. Lynn Tomkins, Scarborough, Ontario
Brig.-General James N. Wright, Ottawa, Ontario

1. Council Meetings

The Meeting of the Membership Committee took place at the Ottawa headquarters, on May 31, 1986. In attendance were Drs. P.R. Crawford, (Chairman), Rita Hurley, Lynn Tomkins, Ed Busvek, Gilles Dubé; and staff members Lydia Allison, Jean Racicot, and Joel Neal. (Unfortunately, due to previous commitments, Drs. Bradley Holmes, President, and Jim Wright were unable to attend).

2. Items for Information - Not Requiring Board Action(a) Supporting Membership

APPENDIX I

The committee reviewed and recommended that eleven members be ratified for Supporting Membership.

(b) Life Membership

APPENDIX II

The committee reviewed and recommended that one member be ratified for Life Membership.

MEMBERSHIP COMMITTEE

3. Items for Information - Not Requiring Board Action

(a) 1986 Campaign

APPENDIX III

A review of the 1986 Campaign was made and it was gratifying to note that there was some small increase in Ontario figures and a considerable rise in Quebec CDA membership. (Appendix attached). At a time when increasing pressure was placed on the "Association \$"; when a substantial increase in Ontario ODA Association fees and RCDS fees has occurred; and when the trend, at least in United States ADA figures, seems to indicate a decrease in voluntary memberships, the goal of CDA in 1986 to at least "hold our own" was achieved.

It is difficult to assess if the more than 240 increase was attributable to increased interest in CDA or whether it was the CDSPI "concern" re Participation Agreement. 1987 will perhaps give us a better indication.

It was generally agreed that the strategies of 1986 worked quite well and that a similar pattern would be followed in 1987. The strategy would include:

1. Letters to Students.
2. As much coverage as possible in CDA, ODA, and ODQ Journals.
3. Student visits/Student activity evenings.
4. Booths at conventions; CDA, ODQ, ODA, and the Toronto All Societies meeting.

(b) Communication Coordinators

The Committee was encouraged by the input and activity of Communication Coordinators in Ontario and was grateful for their endeavours in handling correspondence to prospective members. It was unfortunate that a Coordinators Workshop was unable to be held in 1986 (difficulties in scheduling), and it was strongly recommended that some form of Workshop be held in the fall of 1986 (October 25??) in preparation for the 1987 campaign.

Mr. Joel Neal was requested to check the 1986 budget, the expenditure figures (which were not available at the meeting time) to ascertain if monies were available for a Workshop. Depending upon the monies available, will be the extent that the Coordinators could be informed of membership services, strategies, etc. Planned meetings in Ottawa and/or Toronto and Montreal would depend upon the monies available.

MEMBERSHIP COMMITTEE

3. Items for Information - Not Requiring Board Action

(b) Communication Coordinators - cont'd

Dr. Dubé indicated he would investigate the Quebec societies activities and involvement with CDA and the possibility of deriving CDA membership statistics. It was agreed that a network of Coordinators and visits to Quebec societies would be beneficial.

Dr. Dubé indicated he would investigate the possibility of CDA Management visiting Quebec society meetings in order to bring forward the CDA "message" which would be helpful to gaining membership in that province.

(c) Professional Marketing

Following a suggestion from the last meeting, preliminary information regarding the assistance of professional fund raising campaign was received from two companies - Hinds Brian Reimer Associated Ltd. and International Creating Marketing Inc. It was the decision of the Membership Committee not to utilize professional assistance at this time, but to pursue a proposal for possible integration of professional fund raisers in 1988.

It was the general consensus that the campaign approach, plus the assistance of Communication Coordinators, had worked well in 1986 and no intrinsic change should be contemplated for 1987.

(d) New Grads

The sustained interest in membership of the New Grad was addressed plus the importance of continuing contact. Committee agreed that two recent graduates, Dr. Sam Sgro the current CDA Governor, and Dr. Bernard Jolicoeur, Laval grad 1985, be invited to attend the next meeting of Committee.

MEMBERSHIP COMMITTEE

3. Items for Information - Not Requiring Board Action

(e) Salaried Dentists

The subject of salaried dentists in the voluntary provinces requesting "tax deductibility" of CDA fees was again discussed. It was pointed out (as it had on several other occasions) that Dr. Hicks of Taxation Committee had approached Revenue Canada and Taxation on the very subject. Government it seems, treats the "dentist's employee" like any other employee and does not support the tax deduction of CDA dues. Reference was made to the Report of the Salaried Dentists Committee whereby that committee recommended that a fee reduction for salaried dentists in one or two of the voluntary provinces was not in the best interests of CDA.

However, although no immediate solution to reduced fees for Salaried Dentists was evident, it was urged that CDA Executive Council and the Taxation Committee continue in their endeavours for some tax benefit for the Salaried Dentists.

The Committee indicated their appreciation to the presence of Lydia Allison, the Membership Secretary, and Jean Racicot, Administrative Secretary, at the meeting and requested that these two staff persons be regular attendees. Their assistance and knowledge as to the housekeeping aspects of membership was valuable.

Respectfully submitted,

P. Ralph Crawford, D.M.D.
Chairman,
Membership Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Membership Committee with appreciation.

APPENDIX I

APPLICATIONS FOR SUPPORTING MEMBERSHIP STATUS APPROVED BY MEMBERSHIP COMMITTEE

NAME	PROVINCE	REASON
Dr. Gerard R. Mercier	Quebec	Retired
Dr. Pierre P. Jutras	Quebec	Illness
Dr. Fernand Beaudoin	Quebec	Retired
Dr. Yachiyto Yoneyama	Ontario	Retired
Dr. John G. Woods	Ontario	Retired
Dr. J.G. Millen	Ontario	Retired
Dr. Gilles J. Boucher	Ontario	Retired
Dr. Louis J. Frost	Ontario	Retired
Dr. Gary S. Blackstien	Ontario	Immigrated to Israel, wishes to retain contact and to assure insurance coverage.
Dr. Joseph R. Devine	Ontario	Retired
Dr. David O'Connell	P.E.I.	Ill health

SUPPORTING MEMBERSHIP:

"Any dentist in good standing who is no longer licensed to practise in Canada, or who is fully retired from dental practice, teaching or administration or who presents special mitigating circumstances, or any other person having an interest in the well-being of the Association and who does not otherwise qualify, shall be eligible to apply for admission as a Supporting member and shall become a Supporting member upon approval by the Executive Council and payment of the appropriate fee."

APPENDIX II

APPLICATION FOR LIFE MEMBER STATUS APPROVED BY MEMBERSHIP COMMITTEE

NAME	PROVINCE	REASON
Dr. Sidney Silver	Quebec	Dr. Silver did not qualify under the previous criteria as he did not meet the "last 3 years consecutive" condition. He now qualifies under the new Life Member criteria.

LIFE MEMBERSHIP

"Any dentist who has been a member of the Canadian Dental Association in good standing for a minimum of forty (40) years regardless of age of applicant will, with the approval of the Executive Council, become a Life Member of the Association."

CANADIAN DENTAL ASSOCIATION1986 MEMBERSHIP RETURNS AS AT MAY 31st, 1986

	<u>ONTARIO</u>	<u>QUEBEC</u>	<u>TOTALS</u>
<u>1986</u>			
AT <u>137</u> DAYS			
ACTIVE & AFFILIATE	2,651	1,440	4,091
ASSOCIATE	13	6	19
POST GRAD/STUDENT FEES	<u>75</u>	<u>42</u>	<u>117</u>
<u>TOTAL PAID FEES:</u>	<u>2,739</u>	<u>1,488</u>	<u>4,227</u>
LIFE - PAST PRESIDENTS			
HONORARY	<u>382</u>	<u>143</u>	<u>525</u>
TOTAL	<u>3,121</u>	<u>1,631</u>	<u>4,752</u>

1985AT 137 DAYS

ACTIVE & AFFILIATE	2,581	1,174	3,755
ASSOCIATE	41	23	64
POST GRAD/STUDENT FEES	<u>66</u>	<u>53</u>	<u>119</u>
<u>TOTAL PAID FEES</u>	<u>2,688</u>	<u>1,250</u>	<u>3,938</u>

LIFE - PAST PRESIDENTS

HONORARY	<u>332</u>	<u>116</u>	<u>448</u>
TOTAL	<u>3,020</u>	<u>1,366</u>	<u>4,386</u>

<u>TOTAL PAID FEES</u> 1985	2,696	1,257
1984	2,821	1,257
1983	2,697	1,267
1982	2,495	1,277

cc: Dr Bradley W Holmes
Membership Committee
Anna Spencer, Adv. Mgr.

1.

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

REPORT TO THE 1986 ANNUAL BOARD OF GOVERNORS

Committee Members: Dr. B.W. Holmes, Chairman, Kenora
 Dr. W.R. Bedford, Ottawa
 Dr. K.C. Bentley, Montreal
 Mrs. P. Johnson, Willowdale
 Dr. R. Salois, Sherbrooke
 Rev. R. Thomas, Scarborough

1. Council Meetings

The PRU Committee has held one meeting since the last Board of Governors Meeting, namely on May 31, 1986 in Ottawa.

2. Items for Information - Not Requiring Board ActionRe-examination and Re-affirmation of the Oral Health Personnel Problem(i) Supply Studies

The initial orientation meeting of the committee, held January, 1986, identified the need for a concentrated re-examination and re-affirmation of the oral health personnel problem at present and for the foreseeable future. As the R.K. House studies conducted for CDA in 1982 and 1984 were the only Canadian studies done on a national basis, the committee deemed it mandatory that the conclusions from these studies be critiqued and their validity verified. To this purpose, the studies were forwarded to Dr. D. Lewis of the University of Toronto and Mr. Richard Cameron, of Halifax, who had been involved in a recent manpower study in Nova Scotia.

Drs. Lewis and House and Mr. Cameron attended the May 31 meeting to present their views on the manpower supply data as provided in the House studies. Various areas in the House study conclusions were questioned and disparities with projections contained in the N.S. study were identified. It was generally agreed that variances were the possible result in differences in the Health and Welfare data base utilized in the Nova Scotia study.

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

(ii) Demand Study

The Committee identified the necessity for demand side data. It was agreed that base data already developed by Dr. House through work in B.C. be utilized. The future demand would also require projection. Decrease in dental caries, future directions in periodontal disease, orthodontics and other forms of treatment, as well as the changing attitudes regarding the optimal time between dental visits, would be among the factors to be considered. The need versus the demand for dental treatment is another variable which would require definition. The future of third party insurance is presently being monitored very closely by the carriers, and dental insurance as we know it today may become scarce. The make-up of the future dental team and, specifically, the use of auxiliaries, will also be affected by the supply/demand for dentists.

(iii) Mechanisms/Directions for Solution

It was agreed by the Committee that the following steps be taken as soon as possible:

- (a) Dr. House would review his supply studies, based on comment from Mr. Cameron; valid adjustments would be made.
- (b) A demand side study must be conducted. In this regard, it was agreed that a meeting of university-based experts (from 5-10 in number) should be held. These individuals would work towards credible demand scenarios, working with the B.C. demand study as a base. Specific composition for this working group, and a proposed budget for this phase, would be developed by Drs. House and Lewis, and submitted to CDA in the immediate future.
- (c) A "negotiator/facilitator" type of individual should be identified to meet on an individual basis with those able to affect cutbacks at the universities, the purpose being to reach some general agreement prior to a combined meeting of representatives from all faculties.

It was agreed that the composition of the demand study working group be carefully considered to ensure credible representation. Critics of the manpower over-supply forecast should be included, as should those with knowledge in such fields as endodontics and periodontics.

PROFESSIONAL RESOURCE UTILIZATION COMMITTEE

(iv) Funding

Several areas of funding are being investigated, e.g. the National Health Research and Development Program, Federal Government Conference Funding, and Third Party Carrier contributions.

The Committee agreed that involvement of outside bodies through funding would assist in maintaining the credibility of the findings and solutions of the PRUC.

The possibility for CDA funding of travel, accommodation expenses and consultants' fees for the demand side study was discussed. It was stressed that the profession was not solely responsible to seek solutions to the manpower problem, and that subsidizing of funding should be pursued.

RESOLVED:

86.67 THAT the Professional Resource Utilization Committee be asked to strike a subcommittee. This subcommittee should consist of: two (2) practicing dentists, the dental consultants Dr. R.K. House and Dr. Don Lewis, with the addition of one or two members of the Health Manpower Working Group;

THAT the purpose of the subcommittee shall be to utilize the PRUC data and to prepare a brief on dental manpower to be presented to the Federal/Provincial Health Manpower Planning Group.

ADOPTED

Respectfully submitted,

Bradley W. Holmes, D.D.S.
Chairman, Professional Resource
Utilization Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Professional Resource Utilization Committee with appreciation.

GOVERNMENT RELATIONS

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

SUMMARY OF ON-GOING ACTIVITIES

Schedule of activities and meetings for the period March 1986 - June 1986

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Dir	86-03-24	NIAGARA	W. Wilton	Consultant	Interview Survey
Exec. Dir.	86-03-25	PEAT - MARWICK	D. Dickson	Consultant	Computer Standards
Exec. Dir.	86-03-26	HWC	R. Laframboise	ADM -Corporate	Discussion - HWC Orgn.
Exec. Dir.	86-03-27	HWC	W. Bedford	SDC	Info. Exchange
Exec. Dir. Pres. Chairman - Govt Rel.	86-04-01	NIAGARA FIN HWC	W. Wilton S. Hart D. Kirkwood	Dep. Min. Dep. Min.	Issues Ottawa Orientation
Exec. Dir. Mgt Cttee Exec. Counc.	86-04-02	DHM	D. Michaud P. Glynn D. Nicholson R. Giroux J. Robertson R. Conway	Govt. Reps. -HWC HWC HWC DM - RC-Customs RC-Taxation Finance	
E.F. Allison	86-04-03	HWC	R. Sandercook B. Martinello D. Nicholson	ADA ADA ADM -HWC(MSB)	Dental Services Delivery System - Alberta

GOVERNMENT RELATIONS

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Exec. Counc. Governors Pres. & CEO's Exec. Dir.	86-04-03	CCA	Mark Daniels	DM - CCA	Dinner Address DM - CCA
Exec. Dir. Dir. Accred. Exec. Dir. - NDEB	86-04-09	Govt - NWT	R. Pilot	DM - Intergovt Affairs	Discussion on licensing regts for dentists in NWT
Exec. Dir.	86-04-16	HWC	D. Obonsawin	DG-Operations MSB	Discussion - Operation of Dental Service Delivery System
Exec. Dir.	86-04-21	ODA HWC	J. Gillies D. Nicholson	Exec. Dir. ADM - MSB	ODA Dental Service Delivery Contract
Exec. Dir.	86-04-24	HWC	R. Laine D. Ross	Chief Dental Serv. Review Team Cons. DSRT	Discussion of Terms of reference and visit schedule - DSRT
Exec. Dir.	86-05-21	PSC	E. Baker	Exec. Dir. Staffing Prog. Branch	N.M.A.P.
Mgt Cttee Exec. Dir.	86-05-28	HWC	J. Epp D. Nicholson P. Glynn W. Bedford	Minister ADM - MSB ADM - HSP SDC	Meet with Minister - Discussion of issues related to HWC/CDA working relationship

GOVERNMENT RELATIONS

CDA REP.	DATE	ORGN	PERSONS	TITLE	PURPOSE
Pres. Elect Exec. Dir. Dir. Accred.	86-06-03	Govt.Can. Parliam. Committee Hearing Briefs on Bill C-96	Cttee Members A. McKinnon	Chairman	Presentation of CDA's brief to the Committee
Exec. Dir.	86-06-04	HWC	R. Laframboise	ADM - CORP	
Exec. Dir.	86-06-17	HWC	W. Bedford G. Smith	SDC Dir - National AIDS Centre	- Update - Discussion of relative roles in dissemination of AIDS information
Chairman - Govt Rel.	86-06-25	HWC	D. Michaud	Asst to Min.	CDA/HWC (Ministerial) Relationship
Chairman - Govt Rel.	86-06-25	HWC	D. Nicholson	ADM - MSB	Discussion - ADMs Address to Governors - 86-08-21, Halifax

Respectfully submitted,

Ron J. Markey, D.D.S., M.S.D.
Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Government Relations Committee with appreciation.

TAXATION COMMITTEE

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Committee Members: Dr. Robert N. Hicks, Chairman
 Dr. Bradley W. Holmes
 Dr. P. Ralph Crawford
 Dr. John R. Robertson

1. Items for Information - Not Requiring Board Action1. Federal Sales Tax on Dental Materials

Since the 1986 Interim Board meeting, the Chairman of the Taxation Committee has met with Tax Interpretation division of Revenue Canada - Excise to discuss the tax status of dental materials listed on page 3 of Revenue Canada's letter of January 15, 1986. These materials were listed as "possibly being exempt" depending upon their use, application or type.

APPENDIX I

A submission from CDA dated May 16, 1986 requested that all of these materials, except for cyanoacrylate, be classified as tax exempt under Section 19 of Part VIII Schedule III to the Excise Tax Act since they are dental cements, bases, or liners that form an integral part of the reconstruction of a tooth. Revenue Canada accepted our proposal and stated that a letter will be forthcoming placing the following materials in a tax exempt status:

APPENDIX II

calcium hydroxide
 composite luting
 glass ionomers
 polycarboxylates
 silicate cements
 resin cements
 zinc oxide eugenol
 zinc phosphates

TAXATION COMMITTEE

Dental materials that are used "in the process of" restructuring a tooth but which do not form "part of" the restructured tooth were also discussed at this meeting. These materials, together with Pit and Fissure Sealants will be ruled on at a later date.

This meeting concluded our deliberations with Revenue Canada - Excise on the effects of the May, 1985 Federal Budget on dental materials (i.e. federal sales tax). However, Tax Interpretations confirmed CDA's opportunity to discuss the tax status of any dental material or item at any time in the future.

2. Federal Sales Tax on Orthodontic Appliances and Supplies

The Taxation Committee continued discussions with the Department of Finance on February 14, 1986 with regard to the tax status of orthodontic articles since the Federal Budget of May, 1985. Since "dental instruments" lost their exempt status in the Budget, orthodontic appliances/supplies (previously identified as dental instruments to qualify for tax exemption) are now eligible for 12% federal sales tax.

APPENDIX III

The Committee was unable to persuade the staff of the Commodity Tax division to return these items to their tax exempt status since they were not "dental instruments". A meeting was obtained on May 23, 1986 with the Special Advisor to the Minister of Finance and a more sympathetic and positive response was obtained. It appears that a number of other articles were "caught" in the wording of the May, 1985 Budget that were not intended to be taxable items - similar to the orthodontic items. While specific mechanisms could not be identified, it is the Chairman of this Committee's opinion that the Department of Finance will work towards returning orthodontic/supplies to their previous tax exempt status. This change will take a significant period of time to occur since legislative change may be necessary.

3. Personal Services Business Definition

Previous reports of the Taxation Committee have identified concern that Personal Services Businesses (PSBs) Definition may be applied to Professional Management Companies (PMCs) during an

audit. Application of a PSB definition would place the PMC tax rate at 50% and would, in effect, limit expense deductions of a PMC to one employee's remuneration.

To avoid application of the PSB definition, the Taxation Committee has always advised that the dentist's spouse (a specified shareholder with 10% or greater shares in the PMC) be employed directly by the dentist if the PMC has five or fewer employees.

Our committee has always strongly opposed the PBS definition being applied to PMCs since the intent of the PBS legislation was never meant to be directed at PMCs. A submission dated March 24, 1986 was made to Revenue Canada - Audits outlining our reasons. A meeting occurred on May 23, 1986 with Mr. George Venner, the new Director-General of Audits and two of his staff members. The CDA Executive Director and the chairman of the Taxation Committee represented the CDA.

APPENDIX IV

Following considerable discussion, the Revenue Canada representatives appeared to be sympathetic and supportive of our concerns. CDA continued to emphasize the point that a dentist's spouse should be able to work within the company that she/he owns (i.e. the PMC).

At the conclusion of this meeting, the Revenue Canada representatives indicated that they understood the concerns of the CDA and would study their PSB definition application policy with the intent to relieve CDA's concerns. A letter will be delivered to CDA outlining their conclusions.

4. Convention Expenses

A recent revised Interpretation Bulletin (IT131R) on Convention Expenses states that:

"Effective for taxation use commencing after December 31, 1984, where a convention held in the United States is sponsored by a Canadian Business or professional organization that is national in character, paragraph 9 of Article XXV Canada - United States Income Tax Convention 1980, provides that the expenses incurred in attending the convention are deductible to the same extent that they would be had the convention been held in Canada."

TAXATION COMMITTEE

The IT Bulletin further emphasizes that only Canadian organizations that are national in character are eligible to do this.

A memorandum dated May 16, 1986 has been sent from the Taxation Committee to the CDA Chairman - Advisory Committee on Conventions (Dr. Ron Markey) for consideration in future CDA convention planning.

APPENDIX V

5. Tax Treatment of Charities and Charitable Donations

Tax rulings relating to charities have been finely tuned over the past two years with the end result producing considerable influence on charitable operations and donations.

The Taxation Committee is reviewing the current regulations in order to prepare a report to the CDA. The intent of this effort is to investigate the possibility for CDA to establish a "foundation" to which members of our profession could donate or bequest funds which would benefit certain areas of operation or our national association.

Respectfully submitted,



Robert N. Hicks, D.D.S., M.S.
Chairman, Taxation Committee

ADOPTION OF REPORT

The Board of Governors accepts the report of the Taxation Committee with appreciation.



Dr. Robert N. Hicks, D.D.S., M.S.,
Chairman,
Taxation Committee,
Canadian Dental Association,
1815 Alta Vista Drive,
Ottawa, Ontario.
K1G 3Y6

Votre référence Your file

Notre référence Our file

CN: 1014/1225
File: 9153-1
Code: 7320

January 15, 1986.

Dear Dr. Hicks:

Thank you for your letters of October 22, 1985 and December 10, 1985, regarding the application of sales tax to dental materials and instruments.

You state that orthodontic articles should be considered as "prosthesis" or "materials for use in reconstructive surgery" and be exempt from sales tax under section 19 of Part VIII of Schedule III to the Excise Tax Act.

Dorland's Illustrated Medical Dictionary, Twenty-fifth Edition defines a prosthesis as:

"an artificial substitute for a missing body part, such as an arm or leg, eye or tooth, used for functional or cosmetic reasons, or both",

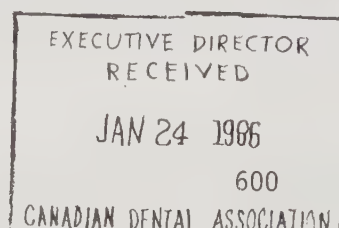
Dental prosthesis:

"a replacement for one or more of the teeth and other oral structure, ranging from a single tooth to a complete denture".

In view of the above, an orthodontic article is not a prosthesis but rather an appliance or apparatus to correct deformities or to improve the function of parts of the body, particularly in the mouth or face. Consequently, an exemption for orthodontic articles would require an amendment to the Excise Tax Act. Amendments to the Act are a matter of tax policy coming under the jurisdiction of the Department of Finance.

After a discussion with officials of the Department of Health and Welfare, I share your view that all dental materials did not become subject to sales tax. However, in my opinion, all dental materials are not exempt from sales tax as materials for use in reconstructive surgery under section 19 of Part VIII of Schedule III to the Act. As indicated hereunder, certain dental materials are subject to sales tax as they do not fit into an existing exempting provision in the Act. Other dental materials qualify for exemption under section 5 or section 19 of Part VIII.

Canada



Department
of National Revenue
(Customs and Excise)

Ministère
du Revenu national
(Douanes et Accises)

... 2

Dental Materials Subject to Sales Tax

Acid gel or solution
Abrasive disks
Acrylic and other tray materials
Articulating papers and waxes
Dental stones
Impression materials
Investment materials
Pit and fissure sealant
Points, antaneous paper
Retraction material - cords, packing material, etc.

Dental Materials Exempt Under Section 5

Gold - dental casting
 - dental alloy solder
 - foil and wire
Surgical arch bars and wire ties
Acrylic resin material
Artificial teeth
Composition metals
Crown and bridge repair materials
Denture reline material
Procelain material
Pins, Posts, Screws

Dental Materials Exempt Under Section 19

Amalgam (and other metal) alloys - caps
 - pellets
 - powder

Cavity liners
Cavity varnishes
Composition filling materials
Crowns - aluminum and plastic
Gutta Percha points
Mercury
Root canal fillers, sealers and cements
Silicate filling materials
Waxes - casting
 - impression
 - inlay/sticky/utility

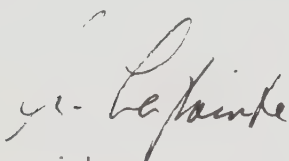
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In addition, the following dental materials may qualify for sales tax exemption either under section 5 or section 19, depending upon their use, application or type:

- calcium hydroxyde
- composite luting
- cyanoacrylate
- glass iononir
- polycarboxylate
- silicate
- resin
- zincoxyd eugenol
- zinc oxyphosphate

I trust that you will find the above satisfactory.

Yours truly,

A handwritten signature in cursive script, appearing to read "A. Lapointe".

A. Lapointe,
Tax Interpretations,
Excise.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 16, 1986

Mr. Mel Hanna
Revenue Canada
Tax Interpretation
Sir Richard Scott Building - Floor 9
191 West Laurier Avenue
OTTAWA
K1A 0L5

Dear Mr. Hanna:

Re: Federal Sales Tax Exemption
Dental Materials

In advance of our May 23rd, 1986 meeting, I would like to provide you with additional information on two unresolved issues that were discussed at our February 14, 1986 meeting.

One issue is the uncertainty of the tax status of certain dental materials listed on page 3 of Mr. Lapointe's letter of January 15, 1986. The second issue is the tax status of dental materials used in the process of dental reconstructive surgery, vis-à-vis dental materials used to specifically restructure dental elements.

ITEM NO 1 - Mr. Lapointe's Letter - Page 3 - Dental Materials

Mr. Lapointe's letter suggests that the following dental materials may qualify for sales tax exemption under Section 5 or Section 19 of Part VIII, Schedule III to the Excise Tax Act.

- Calcium hydroxide (base/liner composition)
- Composite luting (cement)
- Cyanoacrylate (tissue adhesive solution)
- Glass ionomer (cements)
- Polycarboxylate (cements)

.../2

- Silicate (cements)
- Resins (cements)
- Zinc oxide eugenol (base/temp. restoration or cement)
- Zinc phosphate (cements)

Cyanoacrylate is a synthetic tissue adhesive solution often used in periodontal (gum) surgery in place of sutures. This material does not qualify under Section 5 or Section 19 and therefore should not be tax exempt.

The other materials fall into two main categories - dental cements and dental bases (protective/treatment materials). All of these materials are placed within a tooth in conjunction with the restructuring (restorative) material. For example:

- Zinc phosphate cement is placed in a prepared tooth and then amalgam is placed over it.
- Calcium hydroxide is placed in the tooth near the pulp, zinc phosphate cement is placed as a base over it, then amalgam is placed.

Glass ionomer cements, polycarboxylate cements, and zinc oxyphosphate cements are used to cement dental crowns and bridges in place. Composite luting cements are used to attach resin-bonded bridge retainers.

Since all these materials stay within the tooth, and form an integral part of the restructuring process, it is our request that these materials be exempt from federal sales tax under Section 19.

ITEM NO 2 - Dental Materials Used in the Process of Restructuring the Tooth or in the Provision of Artificial Replacement of Teeth (Prosthetic Appliances)

Section 5 states that materials used in the manufacture of artificial teeth are tax exempt, and Section 19 states that materials for use in reconstructive surgery are tax exempt. It is necessary to use the following materials in the process of providing artificial teeth or providing restructuring of existing teeth.

- Acidic gel or solution
- Acrylic or other tray materials
- Dental impression materials
- Retraction materials; cords, packing materials, etc.

These are dental materials expended at the time of the clinical process, but do not remain in the tooth, or become part of the artificial tooth. However, procedures such as restructuring of the tooth, application of restructuring materials, and fabrication of the artificial tooth cannot take place without these materials. They are materials used in the restructuring process (Section 19), and/or in the provision of artificial teeth (Section 5).

It is our request that these materials be included for tax exemption under Section 19.

I will be providing your Department with literature explaining the use of these materials in more detail. If additional information is required, please contact me at (604) 922-0111.

Sincerely yours,



Robert N. Hicks, D.D.S., M.S.
Chairman - Taxation Committee

c.c. Mr. André Lapointe, Tax Interpretations - Excise



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

February 18, 1986

Mr. Raymond Conway, Special Assistant
Office of the Minister of Finance
Place Bell Canada
160 Elgin St. - 27th Floor
OTTAWA (Ontario)
K1A 0G5

Dear Mr. Conway:

RE: Removal of Federal Sales Tax Exemption on Orthodontic
Appliances, Articles and Materials through repeal of Section
21, Part VIII, Schedule III of the Excise Tax Act.

Thank you for the opportunity to meet with you and with Mr.
Gordon Lee, Chief - Commodity Tax Section, on February 14, 1986 for the
purpose of continuing our discussions on the recent 11% federal sales tax on
dental materials, equipment, instruments and particularly on the impact of this
tax on orthodontic treatment items.

The following information and points of concern of the
Canadian Dental Association were presented during our discussions:

1. SUPPORT INFORMATION:

The May, 1985 Federal Budget removed surgical and dental instruments
plus X-Ray Equipment/Supplies from exempt status by repeal of Section
21, Part VIII, Schedule III of the Excise Tax Act.

Following removal of Section 21, two sections in the Act that relate to
dental health remain. Section 5 provides exemption for articles and
materials required in dental treatment that involves replacing missing
teeth with artificial teeth. Section 19 provides exemption for materials
required in dental treatment that involves reconstruction of diseased,
broken teeth and/or their supporting tissues.

.../ 2

As a general rule, where the Excise Tax Act refers to medical health procedure items, the dental health procedure items of a comparable nature are also accepted. As an example of this principle, an interpretation supported by Revenue Canada - Customs and Excise memorandum no 10-8-35 is attached (Appendix I). This type of interpretation has been necessary since the Excise Tax Act is silent in many areas regarding dental health conditions that are of comparable nature to medical health conditions.

The repeal of Section 21 now places appliances, articles, materials, etc., required to reposition teeth (i.e. restructure the occlusion (fitting together) of the teeth to achieve dental health) in a taxable status. The reason for previously qualifying under Section 21 was the interpretation by Revenue Canada - Customs and Excise, that such items be classified as "dental instruments". This very broad interpretation was necessary in order to provide similar status to other items required in comparable areas of dental treatment for the purpose of administration of Customs - Excise matters.

2. AREA OF CONCERN:

The consequence of Revenue Canada's ruling that orthodontic items be defined as "dental instruments", followed by the repeal of Section 21, Part VIII, Schedule III of the Excise Tax Act, has resulted in orthodontic items attracting federal sales tax while items required in other areas related to dental health remain exempt.

A letter from the Minister of Finance (undated) received September 30, 1985, clearly states that the intent of the repeal of Section 21 was to tax the "tools" used in surgical/dental treatment - hence the removal of surgical/dental instruments from exempt status. Orthodontic items are not "tools" by proper definition. Our Association suggests that orthodontic items have been unintentionally taxed following repeal of Section 21.

3. RECOMMENDATIONS:

To place orthodontic items on an equal basis with other medical and dental items identified in the Excise Tax Act, it is necessary to identify such items within one of the existing sections or to create a new section.

Our Association appreciates the technical problems you encounter when making this type of change to the Act and also the concerns you have that such a change will create more access for tax exemption than you intend.

Following a further review of the Excise Tax Act and further discussions with Revenue Canada - Excise Interpretations, it appears that there is reference to medical procedures that involve items required to reposition (restructure) the spine, individual bones/joints, etc., in Section 18. To include repositioning of teeth, but not to expand the intent of the section, the all encompassing term "orthosis" could be used. Medical dictionaries define orthosis as:

"The straightening of a distorted part" - Dorland's Medical Dictionary

"The correction of maladjustment" - Stedman's Medical Dictionary

In order to retain equity between orthodontic items and those items required in other dental/medical health procedures, the Canadian Dental Association suggests that Section 18 could be amended to read:

18. Artificial limbs, with or without power, and all accessories and devices therefore; appliances, articles and materials used in orthosis; parts of the foregoing.

Our Association supports the initiative of the Minister of Finance and the Department to bring the deficit under control and to achieve economic renewal. Our proposal is certainly not intended to narrow the sales tax base that provides a portion of revenue to reach this initiative. However, we strongly feel that the initiative and objectives of the Minister and the Department should be achieved in an equitable and fair manner.

The individual treatment of orthodontic items for taxation while other dental items receive exemption does meet the test of equity and fairness. Likewise, taxation of appliances, articles, materials used in dental treatment, while similar products used in comparable medical treatment receive exemption, would not be fair or equitable.

Thank you again for the opportunity to meet with you and Mr. Gordon Lee. I enjoyed the frank and open discussion we had. Please contact me at (604) 922-0111 if I can provide additional information during your review of this issue.

Sincerely yours,

Robert N. Hicks, D.D.M., M.S.
Chairman - Taxation Committee

/ml
c.c. Mr. Gordon Lee, Chief - Tax Commodity

APPENDIX I

EXTRACT FROM REVENUE CANADA CUSTOMS & EXCISE MEMORANDUM NO. D 10-8-35

"Materials for use in dental reconstructive surgery are those used in the repair or reconstruction of natural teeth or the oral struture, including dental materials used in the surgical correction of a cleft palate such as amalgams or composite filling materials, bone or tooth cement, stains, liners, varnishes."



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

March 24, 1986

Mr. J.R. Robertson, Director General - Audit Directorate
Revenue Canada
123 Slater Street
OTTAWA (Ontario)
K1A 0L8

Dear Mr. Robertson:

RE: Application of Personal Services Business Definition
During Audits of Professional Management Companies

In our meeting on February 14, 1986, I identified the Canadian Dental Association's concern about the Personal Services Business (PSB) definition being used by Revenue Canada during audit procedures of Professional Management Companies (PMCs).

The following information and points of concern were presented during our discussions:

1. Personal Services Business Definition
Re: Section 125 (7) (d) Personal Services Business

Throughout the legislation on Personal Services Businesses, the Income Tax Act refers to individuals who have incorporated themselves and have become "incorporated employees" rather than usual employees. Nowhere in the Act is an incorporated employee who also happens to own 25% or more of the corporation's shares (specified shareholder), considered as an employee of a corporation. The principal test for definition purpose is that an individual providing service has replaced themselves by a personal corporation for the purpose of calculating tax.

In general terms, the legislation identifies a Personal Services Business as a corporation providing services that would usually be provided by an individual, under an employee relationship, to the person or the partnership receiving the services.

The legislation goes further to identify such a person as an "incorporated employee" (and a specified shareholder) in order to clarify a usual employee relationship that has changed to a "corporate relationship" involving the same person.

.../2

The legislation also addresses the situation whereby the incorporated employee hires additional employees to assist in providing the service that "usually" would be provided by the incorporated employee under an employee relationship. Even if the incorporated employee hires two or three persons to assist in providing the service, the status of the Personal Services Business remains.

Summary:

Throughout Section 125 (7) (d), the language refers to an individual who would usually provide their services to a person or partnership in an employee relationship were it not for the interposition of a corporation.

The Section does not refer to services that go beyond what the individual would normally provide as an employee.

2. November 12, 1981 Budget Papers

The Budget Papers supporting the November 12, 1981 Federal Budget which introduced this legislation confirm that the intent of the legislation is directed towards individuals. The Papers clearly identified that the target of the legislation was Incorporated Executives and Senior Employees i.e. individuals who would normally be employees but instead "can gain valuable tax advantages by incorporating themselves and continuing to provide services to their former employee through a personal corporation."

Further definition explains that "this type of incorporation (PSB) permits the conversion of employment income into business income of the personal corporation."

3. Limitation re Personal Services Business expenses Section 18 (1) (p)

This Section deals with allowable expenses of a PSB and addresses the situation where a former or usual employee (now an incorporated employee) decides to hire employees within their PSB to assist in providing service to the firm.

In general terms, Section 18 (1) (p) allows deductions of:

- expenses related to the salary, benefits, or allowances provided to the incorporated employee
- expenses related to the sale of property or negotiation of contracts
- expenses related to legal costs in collecting accounts of services rendered

Summary:

The intent of this Section clearly indicates the legislation accepts the incorporated employee as an individual providing services under a corporate structure rather than under a usual employee status. This Section also indicates that the legislation will not accept expenses occurred in the event that the incorporated employee desires to hire additional persons to assist him/her in providing the usual "employee" services.

When one examines the structure of a Professional Management Company (PMC), none of the general characteristics of a PSB exist. The PMC does not represent a former or usual employee who has incorporated in order to convert individual employment income into business income of a personal corporation. The PMC does not provide an individual service but instead provides many varied services performed by different skilled persons. The PMC does not have an employee who can be classified as an "incorporated employee" as defined in the Income Tax Act.

The PMC may have five or less full time employees. The PMC may have a specified shareholder working in the company but this person cannot be identified as an "incorporated employee" - instead, they are actually an employee of a valid corporation. This specified shareholder's wages are treated as income whether he/she is employed by the PMC or directly by the professional. Once again, the characteristics of a Personal Services Business do not exist within a Professional Management Company.

In our discussion on this matter, I provided the following example related to a dental practice:

- The dentist's wife is a dental assistant and works for her husband in his dental practice.
- At a point in time, the dentist decides to form a PMC to more efficiently operate his practice.
- The PMC includes a receptionist, two dental assistants (one of which is his wife), a dental hygienist, and a bookkeeper.
- The dentist's wife is a specified shareholder in the PMC.

In this example, the PMC provides varied services to the dentist. It is impossible for a single employee to provide all of these services to the dentist i.e. no one person is incorporating themselves and providing the same services as they would as an employee. There is not an "incorporated employee" situation as defined in the PSB definition.

However, current Revenue Canada practice is to classify this PMC as a Personal Services Business because there are not greater than five full time employees in the corporation and a specified shareholder is one of the employees.

It is the Canadian Dental Association's view that the Personal Services Business interpretation should not be applied to Professional Management Corporations as outlined above.

Conclusion:

It is the Canadian Dental Association's view that, in most instances, Revenue Canada's application of Personal Services Business status upon Professional Management Companies is not appropriate. PMC's are not entities which have been created for the purpose of converting personal employment income into business income of a personal corporation.

Our Association would appreciate Revenue Canada - Audit Compliance reviewing their current practice and removing this punitive classification for the reasons outlined in this letter.

This letter is presented as a general overview of the points raised in our February Meeting. I would appreciate meeting once again with you and officials of your Department to discuss additional details on this matter and to answer specific questions that may arise.

Please contact me at (604) 922-0111, if I can be of further assistance.

Sincerely yours,

A handwritten signature in dark ink, reading "Robert Hicks". The signature is fluid and cursive, with the first name "Robert" and last name "Hicks" clearly distinguishable.

Robert N. Hicks, D.D.S., M.S.
Chairman - Taxation Committee

/ml



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

MEMORANDUM

May 16, 1986

TO: Dr. Ron Markey, Chairman
Advisory Committee on Conventions

FROM: Dr. Robert Hicks, Chairman
Taxation Committee

SUBJECT: CDA CONVENTIONS ELIGIBLE
FOR EXPENSE DEDUCTIONS IN
THE CALCULATION OF INCOME TAX

Subsequent to our telephone conversation on the possibility of CDA holding an Annual Convention in the United States, I received revised Interpretation Bulletin 131R on Convention Expenses.

The new February 28, 1986 IT Bulletin states that:

"Effective for taxation use commencing after December 31, 1984, where a convention held in the United States is sponsored by a Canadian business or professional organization that is national in character, paragraph 9 of Article XXV of the Canada - United States Income Tax Convention 1980 provides that the expenses incurred in attending the convention are deductible to the same extent that they would be had the convention been held in Canada."

The IT Bulletin further emphasizes that only Canadian organizations that are national in character are eligible to do this. Provincial associations would not qualify.

If I can provide additional information, please contact me.

c.c. Mr. A. Jardine Neilson, Executive Director
Dr. Bradley W. Holmes, President

/ml

CONVENTION COMMITTEE

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORSItems for Information - Not Requiring Board Action1986 Convention - Halifax, Nova Scotia, August 24-27.

1. Planning for the 1986 Convention proceeds on schedule;
 - all keynote speakers and scientific program participants have been confirmed;
 - the preliminary program was forwarded to all CDA members in April;
 - President and CEO meetings are confirmed for Thursday, August 21 at the Sheraton Halifax;
 - CDA 's Installation Dinner will be held on Friday, August 22 at the Sheraton Halifax;
 - CDA's President's Luncheon is scheduled for Tuesday, August 26 at the World Trade and Convention Centre.
2. To date (June 6, 1986), 101/125 exhibit booths have been sold at a cost of \$800.00 per booth. Booth requests continue to be received and it is hoped that exhibit space will be completely sold shortly.
3. To date (June 25), registration totals are as follows:
 - 294 dentists
 - 109 hygienists
 - 68 assistants
 - 144 spouses
 - 29 children
 - 10 students and technicians

It would appear that registration figures compare to those received for the Ottawa Convention at a similar point in time.

4. Dr. Brian Rinehart, Atlantic Canada's first dental registrant for the Convention, has won a complimentary weekend at the Pines Resort, compliments of Tourism Nova Scotia.

-
5. CDA will hold its early bird draw on June 16, 1986. All fully paid registrants to the Convention (CDA, CDHA and CDAA) are eligible to win two systems passes to any Air Canada destination, except Singapore and Bombay.
 6. For the first time, CDA will offer a full children's program at the Convention. The Convention is being promoted as a family event and to date, twenty children have registered.
 7. Although no simultaneous translation will be available at the Convention, all signs will be bilingual. The preliminary and final Convention programs will be in both English and French and bilingual personnel will be available at registration.
 8. CDA has aggressively promoted the Convention by a variety of different methods. Extensive information on the Convention and vacationing in Nova Scotia, was available at the CDA booth at both the ODA Convention and Les Journées Dentaires. In addition, the Convention was promoted by local personnel at all Atlantic Canada annual meetings. The CDA Journal has carried detailed coverage on the Convention. Two Journal covers have been devoted to the Convention (June and July) with the July issue as a special Convention issue. A Convention ad has been placed in both the ODA and ODQ Journals and notices sent to all east coast state dental associations, and the American Dental Association. A special preliminary Convention Program was forwarded, under separate cover, to all CDA members in April, and the March CDA Communiqué carried special Convention information.
 9. The local Committee has worked aggressively to obtain corporate sponsorship for many Convention activities. To date, over \$20,000.00 has been obtained, with Oral B providing the largest amount - \$10,000.00 toward support of the President's Gala Dinner and Dance. In addition, a number of lectures will be sponsored or co-sponsored throughout the Convention.
 10. The Sheraton Halifax has been designated CDA's headquarters hotel. CDA has obtained meeting rooms and bedroom accommodation for all Board members at this property.
 11. Groups meeting in conjunction with the CDA meeting include:
 - Royal College of Dentists of Canada
 - Canadian Academy of Oral Radiology
 - Academy of Dentistry International (Canadian Fellowship Convocation)
 - Canadian Society of Public Health Dentists
 - International College of Dentists (Canadian Section)
 - Pierre Fouchard Academy Breakfast

CONVENTION COMMITTEE

1987 Convention - Montreal, Quebec, May 24-28

1. CDA is pleased to announce that it will meet conjointly with Les Journées Dentaires in Montreal in 1987.
2. Function space has been reserved at the Palais des Congrès for this joint event and a large attendance is expected.
3. Discussions are currently underway between Les Journées Dentaires and CDA in the planning of this event. Details will be announced as they become confirmed.

1988 Convention - Edmonton, Alberta, August 29-31

1. Planning for this meeting is somewhat in abeyance pending the establishment of an Ad-Hoc Committee on Conventions, and a delineation of the roles and responsibilities of the Ad-Hoc Committee, and the local Chairman and his Committee.

It is anticipated that a structure will be in place shortly and planning can proceed on schedule.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Convention Committee with appreciation.



Agence canadienne de
développement international

Canadian International
Development Agency

Hull (Québec)
Canada
K1A 0G4

Hull, Quebec
Canada
K1A 0G4

Votre référence Your file

le 6 mai 1986

Notre référence Our file

338-70/C45-10

Mr. Hubert Drouin
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Mr. Drouin:

Subject: Dental Preventive and Educational Program

I am pleased to advise you that a contribution of \$5,600 has been approved by CIDA for the project, as outlined in your proposal attached as Annex "D" of this letter. The contribution is subject to the terms and conditions outlined in Annexes A, B and C to this letter.

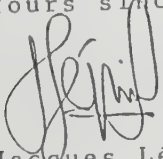
The returning to me of an original signed copy of this letter will signify your agreement to the terms and conditions. A cheque covering our first payment in the amount of \$5,000, as mentioned in Annex "C", will be issued to you promptly.

Many Canadians are not aware that overseas development assistance, through CIDA, involves the participation of so many Canadian individuals and institutions such as yours. The public would no doubt be interested in knowing that government funding of this project will not only produce benefit for people in developing countries but also produce employment and other benefits in our own country. In this light, might we ask that you make mention of CIDA's involvement in any publications, speeches or press releases regarding this project. This would do much to increase Canadian understanding of the international development process.

.../2

May I take this opportunity to wish you every success with your project.

Yours sincerely,



Jacques Lépine
Director
Cooperatives, Unions and
Professional Associations Program
Institutional Cooperation and
Development Services Division

The terms and conditions outlined in Annexes A, B and C of this letter are accepted.

Name: _____ Date: 1986-05-15

A. Jardine Neilson

Title: Executive Director - Canadian Dental Association

Organization: Canadian Dental Association



c.c. Dr. Blackmer
Dr. Holmes
Mr. D. Legris

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 9, 1986

The Honourable Nancy E. Clark Teed
Minister of Health
P.O. Box 6000
FREDERICTON (N.B.)
E3B 5H1

Dear Mrs. Clark Teed:

In 1983, the Canadian Dental Association, the New Brunswick Department of Health and the Canadian International Development Agency jointly sponsored the introduction of a dental preventative and educational program for the school children of St. Kitts/Nevis. Dr. John Blackmer, your Senior Dental Consultant, was the Project Director and as such headed both the exploratory and introductory phases of this project.

The commitment of the New Brunswick Department of Health involved the utilization of expertise in the fluoride mouth rinse program, and gave its agreement to provide this expertise through the services of Dr. Blackmer and Mrs. Mary Pelletier, a dental hygienist with your department at that time. The two phases of the project involved a total of four weeks absence on the part of Dr. Blackmer; the cost of this absence was shared equally by your Department and Dr. Blackmer through use of his accumulated vacation time.

Over the past year, concern has developed that the mouth rinse program in St. Kitts is in jeopardy. There has been a change in dental personnel on the island and the Ministry of Health in St. Kitts, although expressing commitment for the program in the past, now appears reluctant to provide the required funding of supplies to ensure continuation.

The Canadian Dental Association has approached CIDA with its concerns, and has secured approval of a one-week follow-up and evaluation visit by Dr. Blackmer. The CIDA approval also involves funds for supplies. Would New Brunswick again participate by funding Dr. Blackmer's one-week leave of absence?

.../2

Mrs. Nancy E. Clark Teed

- 2 -

86-05-09

The CDA is most appreciative of your Government's past support, and looks forward to an encouraging response.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "A. Jardine Neilson", with a horizontal line drawn underneath the signature.

A. Jardine Neilson
Executive Director

/ml



DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
MINISTÈRE DE LA SANTÉ ET DES SERVICES COMMUNAUTAIRES

CP PO Box 5100
Fredericton, N.-B.
E3B 5G8

(506) 453-2581

OFFICE OF THE MINISTER
CABINET DU MINISTRE

May 30, 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Mr. Neilson:

I wish to acknowledge your letter of May 9, 1986 requesting the support of my Department to allow Dr. John Blackmer, our Senior Dental Consultant to participate in a one-week follow-up visit to St. Kitts/Nevis, to evaluate the continuation of the fluoride mouthrinse program.

It is my understanding this jointly sponsored project was well received and supported by the health and educational staff on the Islands, and that over 99% of the 6000 eligible children initially participated in this worthwhile program. It is indeed unfortunate to learn that this program may be in jeopardy.

Considering our support for the original project, I would be prepared to support one-half of Dr. Blackmer's participation in the proposed follow-up visit. As this project will involve travel outside of Canada, it will be necessary to have Board of Management approval before a final decision is possible. Once we have their decision I will ask Dr. Blackmer to contact you.

Yours sincerely,

Nancy Clark Teed, Mrs.



c.c. Dr. Blackmer
Dr. Holmes
Mr. D. Legris

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 9, 1986

The Honourable Sydney Morris, Minister
Education, Health and Social Affairs
Basseterre
P.O. Box 333
Newstead Building
St. Christopher/St. Kitts
W.I.

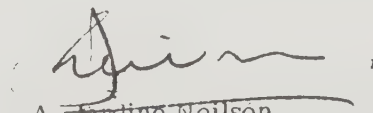
Dear Minister:

As you are aware, the Canadian Dental Association has a continuing and active interest in the dental preventative and educational program for school children in St. Kitts introduced in 1983, and has received reports on the ongoing program from Dr. Julian Mitchell and Dr. J.E.C. Weddup, Government Dentist in St. Kitts.

In recent reports from Dr. Weddup, we noted difficulties experienced with the continuation of the mouth rinse program, and specifically in securing the necessary supplies. As you know, past commitment of funds by the CDA, the New Brunswick Department of Health and the Canadian International Development Agency was considerable, and we are most eager to offer assistance to your Government to ensure that the program enjoy continued success. In this regard, the CDA has approached CIDA, and has recently received approval for a one-week follow-up visit by Dr. Blackmer, and monies to purchase additional supplies.

We would appreciate your Government's agreement to the plans noted above, before proceeding with further, more definite scheduling, of Dr. Blackmer's visit.

Sincerely yours,


A. Jardine Neilson
Executive Director

/ml



c.c.: Dr. Blackmer

ST. CHRISTOPHER AND NEVIS

Ministry of Education, Health & Community Affairs,

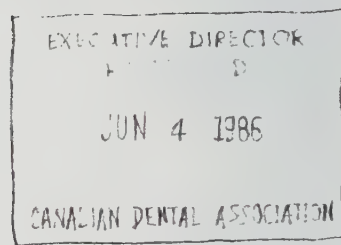
P. O. Box 333,

St. Kitts, W. I.

Ref. No. H/D01

23rd May 1986

The Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa
Ontario
CANADA K1G 3Y6



Dear Sir

I have just received your letter of May 9th which indicates your Association's continuing interest in providing assistance to my Government, and which informs of your recent action in securing funding for additional dental supplies, as well as a visit by Dr Blackmer.

I hasten to first of all express sincere gratitude for this keen interest and consequent action, and further to state that both are welcomed in the continuance of the programme.

Our schools are due their Summer Vacation from July 14th until September 8th when they re-open. I hope this information will assist in the scheduling of Dr Blackmer's visit.

Once again, my heartfelt appreciation.

Sincerely

S Earl Morris
Minister

SEM:saa



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 21, 1986

Mr. Jacques Lépine, Director
Cooperatives, Unions and Professional
Associations Program
Institutional Cooperation and Development
Services Division
Canadian International Development Agency
200 Place du Portage
HULL (Quebec)
K1A 0G4

Dear Mr. Lépine:

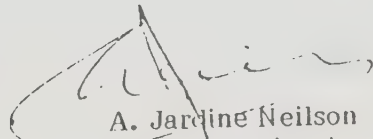
SUBJECT: Dental Preventive and Educational Program
File No. 338-70/C45-10

This will acknowledge your letter of May 6, 1986 addressed to my predecessor Mr. Hubert Drouin on the Dental Preventive and Educational Program for St. Kitts.

Enclosed is the signed original of your letter, signifying the agreement of the Canadian Dental Association to the terms and conditions for the CIDA contribution as outlined in Annexes A, B and C to your letter.

I will ensure that Mr. Denis Legris is kept informed of all developments concerning this project, and I thank you for your good wishes.

Sincerely yours,


A. Jardine Neilson
Executive Director

c.c. Mr. Denis Legris, Director CIDA
Dr. Bradley W. Holmes, President
Ms Carolyn Hackland, Journal Editor
Dr. J. Blackmer, Senior Dental Consultant - New Brunswick



Agence canadienne de
développement international

Canadian International
Development Agency

Hull (Québec)
Canada
K1A 0G4

Hull, Quebec
Canada
K1A 0G4

le 20 mai 1986

Votre référence Your file

Notre référence Our file

338-70/C45-11

M. J. Neilson
Directeur
Association Dentaire Canadienne
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Monsieur,

Objet: Programme de santé dentaire en Haiti

J'ai le plaisir de vous annoncer que l'ACDI a approuvé une contribution de \$26,500 pour le projet exposé dans votre proposition, à l'annexe D de la présente. Cette contribution est assujettie aux modalités et conditions énoncées dans les annexes A, B et C ci-jointes.

Je vous prierais de bien vouloir me retourner une copie signée de la présente pour me signifier que vous acceptez les modalités en question. Tel que prévu à l'annexe C, un premier chèque, d'un montant de \$25,000, vous sera envoyé sous peu.

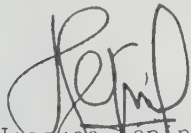
Bien des Canadiens ne savent pas que l'ACDI fait appel à un grand nombre de particuliers et d'institutions comme la vôtre pour réaliser le programme d'aide au développement du Canada. Le public aimerait certainement savoir que les fonds du gouvernement affectés à ce projet ne bénéficieront pas qu'aux peuples des pays en développement, mais contribueront également à la création d'emplois et auront d'autres retombées avantageuses ici même. C'est pourquoi nous vous saurions gré de mentionner la participation de l'ACDI dans vos publications, allocutions ou communiqués de presse éventuels concernant ce projet. Nul doute que cela aiderait nos concitoyens à mieux comprendre le processus du développement international.

.../2

Canada

- 2 -

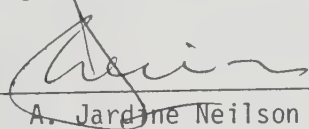
Je profite de l'occasion pour vous offrir tous mes voeux de succès dans la réalisation de votre projet, et vous prie d'agréer, Monsieur, mes salutations les plus distinguées.



Jacques Lépine
Directeur

Direction de la Coopération institutionnelle
et des Services au développement

J'accepte les conditions stipulées dans les annexes A, B, C et D des présentes.



Nom: _____ Date: May 23, 1986

A. Jardine Neilson

Titre: Executive Director

Organization: Canadian Dental Association



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 23, 1986

Mr. Jacques Lépine, Director
Cooperatives, Unions and Professional
Associations Program
Institutional Cooperation and Development
Services Division
Canadian International Development Agency
200 Place du Portage
Hull, Québec
K1A 0G4

Dear Mr. Lépine:

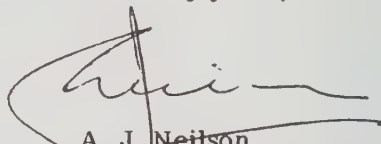
SUBJECT: Oral Health Program - Haiti
Your File No. 338-70/C45-11

It is with pleasure that I acknowledge receipt of your letter of May 20 confirming approval of the CIDA contribution to the Oral Health Program in Haiti.

Enclosed is the signed original of your letter, signifying the agreement of the Canadian Dental Association to the terms and conditions for the CIDA contribution as outlined in Annexes A, B and C to your letter.

I will keep in contact with Dr. Legris as this program progresses, and extend my thanks to him for his past cooperation.

Sincerely yours,



A. J. Neilson
Executive Director

c.c.: Mr. Denis Legris, Director, CIDA
Dr. Bradley W. Holmes, President
Ms. Carolyn Hackland, Journal Editor
Dr. D. Kandelman, Project Director
Mr. Joel Neal, Director of Administration

enc.
/jtf



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CANADIAN DENTAL ASSOCIATION

BRIEF TO THE
LEGISLATIVE COMMITTEE
ON BILL C-96

(AN ACT TO AMEND THE FEDERAL-PROVINCIAL
FISCAL ARRANGEMENTS
AND
FEDERAL POST-SECONDARY EDUCATION
AND
HEALTH CONTRIBUTIONS ACT, 1977)

PRESENTERS: John R. Robertson, DDS
President-Elect, CDA

A. Jardine Neilson
Executive Director, CDA

Arthur Schwartz, DDS
Chairman, Council on Education
and Accreditation, CDA

Brian J. Henderson
Director of Accreditation, CDA

JUNE 3, 1986

The Canadian Dental Association is pleased to have the opportunity to make a brief presentation to the Legislative Committee on Bill C-96 (an Act to Amend the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977).

As the national association representing the dental profession in Canada, we are interested in promoting and assisting positions and developments which will contribute, directly or indirectly, to improved oral health for all Canadians. We recognize the importance of post-secondary educational institutions in preparing dentists and dental auxiliaries and in supporting research initiatives in the field of oral health. We recognize the vital contribution the federal government has been making, under the existing provisions for established program funding, to support the provinces financially and to encourage the growth of a system of health services and a system of post-secondary education consistent with the needs of Canadians in all regions of Canada.

We also recognize the need to contain the federal deficit and to develop funding arrangements that are realistic in matching needs and resources at both the national and provincial levels of government. We understand that within this context, Bill C-96 will address the matter of rates of increase in transfers of federal monies to the provinces for expenditures in health care and post-secondary education.

The Canadian Dental Association does not have the expertise or the resources to assess, with any precision, the financial impact of Bill C-96 on the overall funding for Health Services and Post-Secondary Education. We would be concerned, however, if even a seemingly small annual reduction of two percent in the rate of transfer of federal monies were applied, since the net effect, over the period of five years, would amount to a 3.8 billion dollar funding decrease for services alone, as estimated by the Canadian Hospital Association. With comparable cumulative impact on funding for post-secondary education, there could be a very significant reduction, over a relatively short period of time, in federal funding for these fields. These reductions would have to be met by corresponding increases in provincial funding; we are concerned that provincial governments vary in their ability to respond. Consequently, where regional disparities now exist, compounding could result, and the cherished goal of using federal funding to reduce such disparities would be seriously compromised.

As you are aware, third party insurance plans cover some of the dental health care needs of many Canadians, and Established Program Funding touches many oral health care needs only indirectly. Still, with respect to the oral health requirements of Canadians over the next decade, we anticipate that additional financial support will be required for hospital and institutional dentistry. There is no doubt that the number of senior citizens is increasing, and as noted in a

CDA brief presented to the Task Force on the Allocation of Health Care Resources, March, 1984, the need for Hospital and Institutional Dental Services is increasing in tandem with this growth.

In addition, the Canadian Dental Association is aware that, for over a decade, the faculties of dentistry at Canadian universities have generally faced financial constraints, and reduced federal funding would further constrain their academic well-being and growth. While it might be argued that reductions would be consistent with an oversupply of dental manpower, the faculties of dentistry represent the major research base in Canada related to Oral Health and there have already been concerns expressed about the adequacy of financial support for dental research in the CDA Brief to the Task Force on the Allocation of Health Care Resources, March, 1984 mentioned above.

In summary, the Canadian Dental Association, as an association of health professionals, is concerned that Bill C-96 could have a serious impact on the financial foundation for health services and education across Canada, and could aggravate regional disparities in services. Even if it is supplemented by compensatory programs introduced by the federal government, the security provided by the previous guaranteed levels of support would be lost.

Additionally, as an association of dentists, we are concerned that growing needs for Hospital and Institutional Dentistry and Dental Research initiatives will not be met, if there were to be a reduced level in overall funding.

We respectfully request the fullest consideration of the implications of Bill C-96 and, to the extent possible, maintenance of the levels of federal financial support currently provided by the Established Program Funding arrangements.

Thank you.



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ASSOCIATION DENTAIRE CANADIENNE

MÉMOIRE AU
COMITÉ DE LÉGLISLATION
SUR LE PROJET DE LOI C-96
(LOI MODIFIANT LA LOI DE 1977
SUR LES ARRANGEMENTS FISCAUX
ENTRE LE GOUVERNEMENT FÉDÉRAL ET LES PROVINCES
ET
SUR LA PARTICIPATION FÉDÉRALE AU FINANCEMENT
DE L'ENSEIGNEMENT POSTSECONDAIRE
ET
DES PROGRAMMES TOUCHANT LA SANTÉ)

PRÉSENTATEURS: John R. Robertson, DDS
Président désigné, ADC

LE 3 JUIN 1986

A. Jardine Neilson
Directeur exécutif, ADC

Arthur Schwartz, DDS
Président, Conseil de
l'éducation et de l'agrément, ADC

Brian J. Henderson
Directeur de l'agrément, ADC

L'Association dentaire canadienne est reconnaissante de l'occasion qui lui est donnée de présenter le présent mémoire au Comité de législation sur le projet de loi C-96 (Loi modifiant la Loi de 1977 sur les arrangements fiscaux entre le gouvernement fédéral et les provinces et sur la participation fédérale au financement de l'enseignement postsecondaire et des programmes touchant la santé).

En tant qu'organisation nationale représentant la profession de la médecine dentaire au Canada, l'Association encourage et soutient toute position ou initiative susceptible de contribuer, directement ou indirectement, à l'amélioration de la santé buccale de tous les Canadiens. Elle reconnaît l'importance des institutions d'enseignement postsecondaire, qui participent à la formation des dentistes et des auxiliaires dentaires de même qu'à la recherche dans le domaine de la santé buccale.

L'Association reconnaît qu'en vertu des dispositions actuelles concernant le financement des programmes établis, le gouvernement fédéral a apporté une contribution essentielle au soutien financier des provinces et au développement de services de santé et d'enseignement postsecondaire, qui répondaient aux besoins des Canadiens de toutes les régions du pays.

L'Association reconnaît également le besoin de comprimer le déficit fédéral et de trouver, en matière de financement, des arrangements qui permettront d'ajuster avec réalisme les ressources aux besoins tant au niveau de l'administration provinciale que fédérale. Elle comprend cependant que, dans ce contexte, le projet de loi C-96 portera sur les taux de croissance des transferts monétaires que le gouvernement fédéral verse aux provinces pour couvrir les dépenses des services de santé et de l'enseignement postsecondaire.

L'Association dentaire canadienne n'a ni la compétence ni les ressources pour évaluer avec précision la portée du projet de loi C-96 sur le financement des services de santé et de l'enseignement postsecondaire. Elle s'inquiète, cependant, des effets que pourrait avoir une réduction annuelle de deux pour cent de la croissance de ces transferts, puisque une telle réduction, apparemment faible, pourrait entraîner, sur une période de cinq ans, une diminution globale de 3,8 milliards de dollars de la participation fédérale au financement des seuls services, selon une estimation de l'Association des hôpitaux du Canada. Si la loi devait avoir des effets cumulatifs similaires sur le financement de l'enseignement postsecondaire, on assisterait, en très peu de temps, à une diminution importante de la participation financière du gouvernement fédéral dans ces domaines, diminution que les provinces devraient compenser en augmentant leur propre participation. Or, nous doutons que celles-ci soient davantage en mesure de le faire.

En conséquence, une telle mesure risque d'aggraver davantage les disparités régionales, là où elles existent, comme c'est le cas pour les provinces de l'Atlantique, compromettant ainsi sérieusement l'objectif tant recherché de réduire ces disparités grâce à la participation financière du gouvernement fédéral.

Comme vous le savez, l'assurance dentaire couvre certains des soins dont beaucoup de Canadiens ont besoin, tandis que le financement des programmes établis ne répond qu'indirectement à bon nombre de besoins en matière de santé buccale. Néanmoins, nous prévoyons qu'au cours de la prochaine décennie, les services dentaires des hôpitaux et des institutions devront compter sur un appui financier encore plus grand dans ce domaine. En effet, il ne fait aucun doute que le nombre des personnes âgées augmente et que les besoins des services dentaires des hôpitaux et des institutions s'accroissent au même rythme, ainsi que l'ADC le notait dans un mémoire qu'elle présentait, au mois de mars 1984, à un groupe de travail sur la répartition des ressources dans les services dentaires de santé.

Par ailleurs, l'Association dentaire canadienne sait que les facultés de médecine dentaire des universités du pays éprouvent des difficultés financières depuis plus de dix ans et qu'une réduction du financement fédéral ne ferait qu'aggraver leur situation. On peut prétendre qu'une telle réduction serait opportune dans un contexte où on dénombre un surplus de personnel dentaire, mais il n'en demeure pas moins qu'au Canada, c'est dans ces facultés d'abord et surtout que se fait la recherche dans le domaine de la santé buccale et qu'on s'est toujours inquiété du manque de soutien financier pour ce genre de recherche, ainsi que l'ADC le soulignait dans son mémoire de mars 1984 au groupe de travail mentionné ci-dessus.

Bref, en tant qu'organisme regroupant des professionnels de la santé, l'Association dentaire canadienne craint que le projet de loi C-96 n'ait des conséquences néfastes sur le financement des services de santé et sur l'enseignement au pays et n'aggrave encore davantage les disparités régionales dans le domaine des services. Même si d'autres programmes fédéraux venaient atténuer ces effets, les institutions perdraient la sécurité que leur assurait jusqu'ici l'appui financier du gouvernement.

De plus, en tant qu'association de dentistes, l'ADC craint qu'une réduction générale du financement ne permette plus aux services dentaires des hôpitaux et des institutions ni aux organismes de recherche dentaire de répondre aux besoins qui augmentent sans cesse dans ces domaines.

L'Association demande respectueusement que l'on examine très attentivement les implications du projet de loi C-96 et que l'on maintienne, dans la mesure du possible, à son niveau actuel l'appui financier que le gouvernement fédéral accorde en vertu des arrangements sur le financement des programmes établis.

Merci.

CANADIAN DENTAL ASSOCIATION
BRIEF TO THE
TASK FORCE ON THE ALLOCATION OF
HEALTH CARE RESOURCES
MARCH 30, 1984 - OTTAWA

PRESENTERS: DR. P. R. CRAWFORD, PRESIDENT-ELECT
DR. W. R. THOMPSON, PAST-PRESIDENT

THE CANADIAN DENTAL ASSOCIATION APPRECIATES THE OPPORTUNITY TO EXPRESS ITS VIEWS AND CONCERNS TO THE TASK FORCE ON THE ALLOCATION OF HEALTH CARE RESOURCES.

LIFE-THREATENING PROBLEMS ARE NOT THE DAILY BREAD OF DENTISTRY, BUT, DENTISTRY MOST CERTAINLY AFFECTS AND INFLUENCES THE "WELL-BEING" OF ALL CANADIANS. PERHAPS IT IS BECAUSE LIFE-THREATENING CONDITIONS LIKE DIABETES, HEART AILMENTS AND A HOST OF OTHER DISEASES ARE NOT INVOLVED IN DENTISTRY THAT THE FEDERAL DEPARTMENT OF HEALTH AND WELFARE HAS CHOSEN TO IGNORE DENTISTRY ON TWO RECENT OCCASIONS: IN 1981 IN THE REPORT OF THE AD HOC COMMITTEE ON NATIONAL HEALTH STRATEGIES, AND AGAIN IN 1983, AT THE SECOND CONFERENCE ON AGING, DENTAL HEALTH WAS NOT EVEN MENTIONED.

STILL, THERE IS PLENTY OF EVIDENCE OF THE IMPORTANCE OF DENTISTRY IN THE CANADIAN HEALTH CARE SYSTEM. RELIABLE STUDIES INDICATE THAT 90% OF 13, 14, AND 15 YEAR OLDS HAVE EXPERIENCED TOOTH DECAY: AND 75% OF DENTATE ADULTS SUFFER FROM PERIODONTITIS (GUM DISEASE).

THE CANADIAN DENTAL BILL IS APPROXIMATELY 1½ BILLION DOLLARS PER YEAR. IT IS ESTIMATED THAT FOR EVERY 2.6 DOLLARS

SPENT ON MEDICAL COSTS, 1 DOLLAR IS SPENT ON DENTISTRY. IN ADDITION, WHEN LOSS OF TIME FROM THE WORK PLACE OR FROM THE CLASSROOM PLUS TRAVEL TIME INVOLVED AND INCONVENIENCE AND DISCOMFORT ARE TAKEN INTO ACCOUNT DENTAL DISEASE IS A MAJOR HEALTH CONSIDERATION WITH SIGNIFICANT IMPACT ON SOCIETY.

DOWN THROUGH THE YEARS, CANADIAN DENTISTS, THEIR PROFESSIONAL ORGANIZATIONS AND SCHOOLS OF TRAINING, HAVE BEEN STEADILY MEETING THE CHALLENGE OF COMBATTING DENTAL DISEASE.

- 25 YEARS AGO THERE WERE FIVE DENTAL COLLEGES IN CANADA, TODAY THERE ARE TEN, GRADUATING ABOUT 400 DENTISTS A YEAR.
- 25 YEARS AGO THERE WERE 5,470 DENTISTS IN CANADA, SERVING 17,625,000 CANADIANS. TODAY, THERE ARE ABOUT 12,000 DENTISTS SERVING 25,000,000 CANADIANS: A RATIO OF 1:2,000.
- 25 YEARS AGO THERE WERE ONLY 65 DENTAL HYGIENISTS IN ALL OF CANADA, TODAY THERE ARE NEAR 5,000.

THE DEDICATION OF EDUCATORS AND PRACTITIONERS, COUPLED WITH ADVANCES IN TECHNOLOGY HAVE MADE DENTAL TREATMENT AVAILABLE

IN CANADA COMPARABLE WITH THE BEST IN THE WORLD.

ALONG WITH LARGER NUMBERS OF DENTISTS, A NUMBER OF DEVELOPMENTS HAVE CONTRIBUTED TOWARDS THE ELIMINATION OF DENTAL DISEASE. THESE INCLUDE THE DEVELOPMENT OF THE HIGH SPEED DENTAL ENGINE: IMPROVED QUALITY OF RESTORATIVE AND PROSTHETIC MATERIALS: SOPHISTICATED ADVANCES IN PROCEDURES TO CORRECT JAW-DEFORMITIES AND IMMENSE STRIDES IN THE UTILIZATION OF PARA-PROFESSIONAL PERSONNEL.

A LARGE PART OF THE FOUNDATION UPON WHICH MODERN DENTISTRY IS BUILT, IS THE INTRODUCTION OF FLUORIDATION. PROBABLY NO SINGLE DEVELOPMENT HAS CONTRIBUTED MORE TO THE DECREASE IN DENTAL DECAY, PARTICULARLY IN CHILDREN, THAN FLUORIDATION. IT IS INDEED UNFORTUNATE THAT NUMEROUS RURAL REGIONS, AND METROPOLITAN AREAS SUCH AS MONTREAL, CALGARY, AND VANCOUVER WITH A COMBINED POPULATION OF 5 MILLION PEOPLES (1/5 OF CANADA) STILL DO NOT TAKE ADVANTAGE OF A SIMPLE, COST EFFECTIVE MECHANISM THAT CAN REDUCE THE DECAY RATE BY AS MUCH AS 60%.

ALONG WITH THE BENEFICIAL IMPACT OF FLUORIDATION, ADVANCES IN TECHNOLOGY, AND INCREASING NUMBERS OF DENTISTS AND AUXILIARIES, THERE IS A PARALLEL GROWING CONCERN IN CANADA THAT IN FACT, WE MAY BE FACING A MANPOWER PROBLEM, I.E., TOO MANY DENTISTS. THIS IS NOT A PERCEPTION CONFINED TO CANADA NOR THE UNITED STATES ... SOME DENTAL SCHOOLS IN SWEDEN, DENMARK, AND OTHER WESTERN EUROPEAN CITIES ARE EITHER CLOSING OR CURTAILING ENROLLMENT. THIS MAY, HOWEVER, TURN OUT TO BE MORE OF A PERCEIVED PROBLEM THAN A REAL PROBLEM. A REVIEW OF FUTURE NEEDS MAKES THIS APPARENT.

THE EXPECTATION OF THE PUBLIC ... ACCUSTOMED TO HIGHER LEVELS OF SERVICE AND AMENITIES IN THE 1970'S AND EARLY 80'S ... IS THAT DENTAL CARE AND TREATMENT IS A RIGHT AND NOT A PRIVILEGE. THE DENTAL PROFESSION AGREES WITH SUCH AN EXPECTATION BUT ALSO STRESSES THAT THE RIGHT MUST BE EARNED AND THAT SELF-PREVENTION OF DENTAL DISEASE IS THE RESPONSIBILITY THAT ACCOMPANIES THE RIGHT.

DENTISTS HAVE ALWAYS KNOWN THAT THE TWO DENTAL DISEASES -- CARIES AND PERIODONTAL DISEASE -- ARE VIRTUALLY PREVENTABLE. TO DATE, THERE IS NO "MAGIC CURE, NO MIRACLE PILL". IT IS A MATTER OF PATIENT/PUBLIC "PARTICIPATION".

PRESENTLY, THE CDA IS LAUNCHING AN "AWARENESS PROGRAM" AIMED AT PROMOTING AWARENESS OF THAT INDIVIDUAL RESPONSIBILITY FOR PREVENTION. STUDIES HAVE INDICATED THAT ALMOST 50% OF CANADA'S POPULATION DO NOT REGULARLY SEEK DENTAL CARE ... ONLY SEEKING OUT SERVICES WHEN THE "NEED" (USUALLY PAIN) ARISES. BY THAT TIME IT IS OFTEN TOO LATE. FURTHER STUDY INDICATES THAT IT ISN'T NECESSARILY ECONOMIC FACTORS THAT DELAY REGULAR PREVENTIVE DENTAL CARE -- IT IS SELF DIAGNOSIS AND COMPLACENCE. ALL TOO OFTEN, THAT 45% TO 47% OF THE POPULATION WHO VISIT THE DENTIST IRREGULARLY SEEM TO CONCLUDE "I DON'T NEED DENTAL CARE" AND PUT IT OFF FOR A LATER DAY.

THE CDA'S "AWARENESS PROGRAM" IS INTENDED TO ADDRESS THIS PROBLEM. WE WANT TO HELP FELLOW CANADIANS REALIZE THAT REGULAR CARE AND PREVENTION -- WHAT WE CALL "AWARENESS" -- CONTRIBUTES TO DENTAL WELL-BEING, AND DESERVES HIGHER PROFILE. LIKE PARTICIPATION -- WE URGE THE "THREE MINUTE DAILY WORKOUT" WHICH IS PRESENTLY BEING EMPHASIZED IN OUR NATIONAL DENTAL HEALTH PROJECT FOR THE MONTH OF APRIL.

POSSIBLY ONE OF THE GREATEST CHALLENGES OF THE FUTURE IS IN THE AREA OF DENTISTRY FOR THE AGED. WE DO NOT HAVE TO BELABOUR THE MULTITUDE OF GERIATRIC STATISTICS, EXCEPT TO REMIND THE TASK FORCE THAT BY THE YEAR 2001, THE NUMBER OF PEOPLE IN

CANADA OVER 65 WILL RISE FROM 8% OF THE POPULATION TO ABOUT 12% ... A NUMERICAL INCREASE FROM 2 MILLION TO 4 MILLION IN THE SHORT SPAN OF 16 YEARS.

A GENERATION AGO, THE THRUST OF DENTAL CONCERNS WAS IN CHILDREN'S DENTISTRY ... ALTHOUGH WE HAVE NOT ENTIRELY SOLVED THAT CONCERN, WE HAVE PROVEN TO OURSELVES AND GOVERNMENTS THAT WITH PLANNING, DEDICATION AND DETERMINATION WE CAN ENHANCE THE DENTAL WELL-BEING OF AN ENTIRE SEGMENT OF SOCIETY. TODAY, TOMORROW, WE MUST MEET THE CHALLENGE OF ASSISTING CANADA'S GROWING NUMBER OF ELDERS TO ATTAIN AND RETAIN MAXIMUM ORAL HEALTH.

IT IS A FORMIDABLE BUT NOT IMPOSSIBLE TASK. IT IS SURELY ONE WHICH PERSONIFIES THE IMPORTANCE OF PLANNING, DIRECTION AND AWARENESS.

THE ELDERLY PRESENT SPECIAL PROBLEMS IN DENTISTRY, DAILY PREVENTIVE ROUTINES, ROOT CARIES, PERIODONTAL DISEASE, SUITABLE PROSTHESIS REPLACEMENT ARE PART OF THEIR SPECIFIC DENTAL NEEDS. ALL TOO OFTEN, THE ELDERLY WHO REQUIRE COMPLEX TREATMENT ARE THE LEAST ABLE TO ATTAIN IT. ECONOMICS, ACCESS AND MOBILITY, MOTIVATION ARE SOCIAL CONCERNS TO BE SHARED BY THE PATIENT, BY THE DENTAL PROFESSION AND BY SOCIAL AGENCIES.

IT WAS INTERESTING TO HEAR MR. BUD SHERMAN, DEPUTY HOUSE LEADER OF THE OPPOSITION AND HEALTH CRITIC, IN THE MANITOBA LEGISLATURE, REPLY TO YOU MADAM CHAIRPERSON, WHEN ASKED WHAT THE MAIN HEALTH CHALLENGES FACING US IN THE NEXT DECADE-AND-A-HALF OF THIS CENTURY WERE...

1. MENTAL HEALTH
2. GERIATRIC CARE
3. DENTAL HEALTH, PARTICULARLY IN THE REMOTE AREAS ... AND WE COULDN'T AGREE MORE!!

AND IT IS THIS CHALLENGE THAT THE CANADIAN DENTAL ASSOCIATION IS WILLING TO MEET.

HOW DO WE ASSESS AND ADDRESS THESE CHALLENGES?

- BY DEVELOPING AWARENESS OF DENTAL HEALTH FOR ALL.
- BY FACING THE GROWING REQUIREMENTS OF THE ELDERLY AND HANDICAPPED PATIENTS
- BY BRINGING COMPREHENSIVE DENTAL CARE TO REMOTE AREAS

THE DENTISTS OF CANADA ARE NOT LOOKING FOR HUGE HANDOUTS OF PUBLIC FUNDS -- THEY ARE LOOKING FOR ENHANCED

COOPERATION FROM SOCIETY AND GOVERNMENTAL AGENCIES.

IN PROMOTING AWARENESS, WE NEED ALL THE HELP WE CAN GET. A NATIONAL DENTAL HEALTH CAMPAIGN IS A FORMIDABLE BUT NOT IMPOSSIBLE TASK — IT IS JUST VERY EXPENSIVE. WHEN WE REALIZE THE VAST SUMS EXPENDED ON METRIC CONVERSION, ON PARTICIPATION, ON BILINGUALISM — ALL NECESSARY AND WORTHY PROGRAMS — WE THINK ABOUT WHAT A FRACTION OF THESE SUMS COULD DO TO PROMOTE ORAL HEALTH. IT IS ALSO NO SECRET THAT WHEN WE COMPARE THE \$'S AND THE MANPOWER EXPENDED IN THE FEDERAL DEPARTMENT OF HEALTH AND WELFARE ON MEDICAL PURPOSES TO MANPOWER AND MONEY DEVOTED TO DENTISTRY FEDERAL SPENDING RE DENTISTRY IS DISPROPORTIONATELY MINISCULE. WITHIN THE ENTIRE HEADQUARTERS OF HEALTH AND WELFARE IN OTTAWA, THERE ARE WELL OVER ONE HUNDRED PHYSICIANS AND BUT ONE DENTIST.

HOW MUCH CAN ONE DENTIST ACCOMPLISH? IT IS UNDERSTANDABLE THAT SUCH NECESSARY ITEMS AS DENTAL PLANNING, DENTAL RESEARCH, DENTAL PROMOTION, TESTING OF DENTAL PRODUCTS FOR SAFETY, ETCETERA: HAVE RECEIVED INADEQUATE PRIORITY, AND HENCE INADEQUATE FUNDING.

EARLIER WE REFERRED TO THE GROWING NUMBERS OF DENTISTS AND WHAT IS OFTEN REFERRED TO AS "THE MANPOWER PROBLEM". WITH

PROPER PLANNING AND ALLOCATION OF RESOURCES, WE SUGGEST THAT THE GROWING NUMBERS OF DENTISTS CAN CAPABLY SOLVE THE DENTAL CONCERNS OF BOTH THE AGED AND THOSE RESIDENTS OF ALL AGES LIVING IN CANADA'S REMOTE AREAS.

SETTING UP A VIABLE DENTAL PRACTICE IS A VERY EXPENSIVE VENTURE -- ESPECIALLY FOR THE YOUNGER GRADUATE -- AND THIS PRACTICE MUST BE IN A LARGE ENOUGH COMMUNITY TO CONTINUOUSLY SUSTAIN AN OVERHEAD EXPENSE OF NEAR 65%. NEITHER THE REMOTE HAMLET NOR THE SENIOR CITIZEN RESIDENCE OR INSTITUTION LEND THEMSELVES WELL TO SOLVING THIS DILEMMA OF ECONOMIC VIABILITY.

BUT, AND THIS IS ENCOURAGING, COOPERATIVE EFFORTS BETWEEN GOVERNMENTS AND THE DENTAL PROFESSION CAN DO MUCH TO ASSIST ALL CONCERNED.

FOR EXAMPLE, A JOINT VENTURE BETWEEN THE FEDERAL BRANCH OF MEDICAL SERVICES AND THE UNIVERSITY OF MANITOBA, IS COST EFFECTIVELY BRINGING MUCH NEEDED DENTISTRY TO FAR FLUNG AREAS IN THE CENTRAL NORTH WEST TERRITORIES. ANOTHER PROGRAM -- A COOPERATIVE AGREEMENT BETWEEN MEDICAL SERVICES AND THE ONTARIO DENTAL ASSOCIATION -- IS WORKING WELL IN NORTH WESTERN ONTARIO, AND SOON TO BE EXPANDED.

PROVISION OF DENTAL CARE IN REMOTE AREAS OF CANADA WILL NEVER BE EASY, BUT THE ABOVE EXAMPLES INDICATE IT CAN BE DONE. THE CANADIAN DENTAL ASSOCIATIONS, NATIONAL AND PROVINCIAL, ARE ONLY TOO WILLING TO DO THEIR PROFESSIONAL BEST, BUT ALL GOVERNMENTS MUST GIVE HIGHER PRIORITY TO DENTAL HEALTH.

WITH THE GROWING NUMBERS OF ELDERLY CITIZENS, WE ARE ALREADY BEHIND IN PROPER PLANNING TO MEET DENTAL NEEDS. ALL TOO OFTEN SENIOR CITIZEN RESIDENCES, PERSONAL CARE HOMES AND INSTITUTIONS HAVE BEEN ERECTED WITHOUT PROPER FACILITIES TO DENTALLY EXAMINE AND TREAT THOSE INVOLVED. DENTAL ARRANGEMENTS AND TREATMENT OFTEN HAS TO BE "MAKESHIFT" AT BEST.

TRANSPORTATION OF THE INSTITUTIONALIZED: THE ILL, THE HANDICAPPED, OR EVEN THE PARTIALLY IMMOBILIZED PATIENT, TO A SUITABLE DENTAL ENVIRONMENT IS A VERY INCONVENIENT AND COSTLY PROCEDURE. THE PROFESSION CANNOT BE EXPECTED TO GET INTO THE TRANSPORTATION BUSINESS BUT YOU CAN BE ASSURED OF THE PROFESSION'S COOPERATION AND MANPOWER IF ALLOCATION OF FUNDS WERE SUFFICIENT TO PROVIDE FOR SUITABLE TREATMENT FACILITIES AND/OR TRANSPORTATION SOLUTIONS.

AGAIN MADAM CHAIRPERSON, REFERRING TO MR. SHERMAN'S REMARKS TO THE TASK FORCE ON FEBRUARY 14TH, HE INDICATED THAT THE CHALLENGE OF DENTAL HEALTH BY NECESSITY INVOLVED THE EXPERTISE OF THE PRIVATE PRACTITIONER. THE CANADIAN DENTAL ASSOCIATION HAS BEEN ON RECORD ON NUMEROUS OCCASIONS AS BEING IN FAVOUR OF THIRD-PARTY ASSISTED DENTAL SCHEMES. OUR PARTICULAR CONCERN HAS ALWAYS BEEN THAT WHENEVER THE PROFESSION IS EXCLUDED IN EITHER PLANNING OR INITIATING DENTAL PROGRAMS — BE THEY FOR CHILDREN, FOR SENIORS, FOR REMOTE RESIDENTS — ARRANGEMENTS ARE UNSATISFACTORY AND SOMEONE SUFFERS — AND IT IS INVARIABLY THE PATIENT.

THE DENTAL PROFESSION HAS THE EXPERTISE, THE MANPOWER, THE WILLINGNESS AND THE ENTHUSIASM. WHAT WE NEED MOST OF ALL IS COOPERATION, TRUST, AND A MORE EQUITABLE ALLOCATION OF TAXPAYER'S MONEY IN SUPPORT OF DENTAL HEALTH CARE NEEDS.

AS A FINAL COMMENT, WE MUST MAKE REFERENCE TO RESEARCH, AND RESEARCH FUNDS. OUR PROFESSION HAS DEVELOPED ITS EXPERTISE IN DENTAL CARE BECAUSE DEDICATED DENTAL RESEARCHERS HAVE TO SOME EXTENT FOUND DEDICATED FINANCIAL SUPPORTERS TO SUPPORT THEIR PROJECTS. THIS MUST CONTINUE.

A BIG QUESTION IN THE ALLOCATION OF HEALTH CARE RESOURCES IS THE FRACTION WHICH SHOULD BE DEVOTED TO RESEARCH. RESEARCH IS NECESSARY TO CREATE NEW KNOWLEDGE FOR IMPROVING THE CURRENT METHODS OF PREVENTING AND TREATING DENTAL DISEASES. THE FEDERAL GOVERNMENT PRESENTLY HAS A TARGET THAT 1.5% OF THE GNP BE ALLOCATED TO RESEARCH AND DEVELOPMENT. BASED ON A TOTAL EXPENDITURE OF ABOUT \$1.5 BILLION PER YEAR ON DENTAL CARE, ABOUT \$22 MILLION OUGHT THEN TO BE ALLOCATED TO DENTAL RESEARCH. THIS MEANS THAT EXISTING EXPENDITURES ON RESEARCH SHOULD BE INCREASED BY 4-5 TIMES FROM THE APPROXIMATE \$4 MILLION EXPENDED AT THE PRESENT TIME.

DENTAL RESEARCH IS CARRIED OUT ALMOST ENTIRELY BY THE STAFF OF THE TEN DENTAL SCHOOLS AND MOSTLY BY PROFESSORS WHO HAVE ADDITIONAL HEAVY TEACHING AND ADMINISTRATIVE RESPONSIBILITIES. PERHAPS THE BIGGEST NEED IS FOR CREATION OF DENTAL RESEARCH PROFESSORSHIPS ON A COMPETITIVE BASIS SO THAT SUITABLE PERSONS CAN BE RELIEVED OF THEIR OTHER ACADEMIC DUTIES AND DEVOTE MOST OF THEIR TIME TO RESEARCH. A SUITABLE TARGET MAY BE TWO PERSONS PER SCHOOL FOR SALARY AND RESEARCH OPERATING EXPENSE SUPPORT IN ADDITION TO CURRENT EXPENDITURES ON RESEARCH.

AN EXAMPLE OF THE VALUE OF RESEARCH IN SUCH A SPECIFIC AREA IS EVIDENT IN THE UNITED STATES WHERE \$2 BILLION HAS BEEN SPENT ON DENTAL RESEARCH SINCE 1948. INDICATIONS NOW ARE THAT THIS EXPENDITURE IS SAVING THE DENTAL CONSUMER \$2 BILLION A YEAR IN DENTAL BILLS.

IN SUMMARY, THE CANADIAN DENTAL ASSOCIATION WISHES TO MAKE KNOWN ITS CONCERNS FOR MAXIMUM ORAL HEALTH TO ALL CANADIAN CITIZENS: ITS CONCERN FOR THE GERIATRIC AND HANDICAPPED: FOR COMPREHENSIVE DISTRIBUTION OF DENTAL SERVICES AND FOR RESEARCH. THE ASSOCIATION IS NOT "MARRIED" TO THE PHILOSOPHY THAT IMMENSE SUMS OF MONEY ARE REQUIRED FROM THE PUBLIC PURSE. BUT THERE IS NO DOUBT THAT ALL CANADIANS WOULD BENEFIT FROM A GREATER DEGREE OF COOPERATION AND DISCOURSE ON DENTAL HEALTH ISSUES BETWEEN GOVERNMENTS AND THE PROFESSION. AND FROM THE MORE EQUITABLE ALLOCATION OF FUNDS TO DENTAL HEALTH CARE.

THANK YOU.



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE
1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

May 16, 1986

Dr. Peter Glynn, Assistant Deputy Minister
Health Services & Promotion Branch
Health & Welfare Canada
Jeanne Mance Building
Tunney's Pasture
OTTAWA (Ontario)
K1A 1B4

Dear Peter:

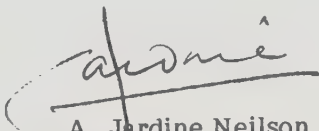
I understand that a National Aids Centre will be established, for the purpose of gathering, analysing, clearing and distributing AIDS information on a national basis.

As you know, the Canadian Dental Association has had a representative member on the National Advisory Committee on AIDS, in the person of Dr. John Hardie. If national health organizations are to be asked to name representatives or committee members to the National Aids Centre, Dr. Hardie would be the CDA nomination.

Incidentally, it would be CDA's intention to continue to act as dentistry's authoritative national voice and distribution point, on AIDS matters of interest to its corporate members in the Provinces.

I would appreciate the opportunity of meeting with you to discuss this progressive step in health information management.

Sincerely yours,


A. Jardine Neilson
Executive Director

/ml



Health and Welfare
Canada

Santé et Bien-être social
Canada

Health Services
and Promotion
Branch

Direction générale
des services et de la
promotion de la santé

c.c.: Dr. Holmes
Dr. Hardie

Your file Votre référence

Our file Notre référence

JUN 3 1986
JUN 3 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario
K1A 1B4

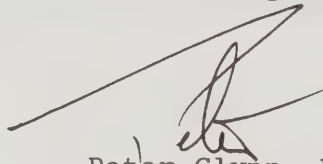

Dear Mr. Neilson:

Thank you for your letter of May 16, 1986,
concerning the activities of the National AIDS Centre.

In order to clarify the role of the Canadian
Dental Association representative with respect to
the National AIDS Centre, it would be useful for you
to meet with Mr. G. Smith, Coordinator, National AIDS
Centre, Dr. W. Bedford, Senior Consultant in Dentistry,
and Dr. A. Meltzer, Senior Medical Advisor - AIDS.
Mr. Smith may be contacted at the following number
993-7570.

I wish to take this opportunity to thank your
Association for its strong input and interest in the
Health and Welfare AIDS program. I know that the
professional expertise available through your members
will continue to be most useful as far as the enhanced
federal AIDS program is concerned.

Yours truly,



Peter Glynn, Ph.D.
Assistant Deputy Minister

Ottawa, Ontario
K1A 1B4

Ottawa, Ontario
K1A 1B4

Canada



The Canadian Medical Association

L'Association médicale canadienne

May 2, 1986

Mr. A. Jardine Nielson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, ON
K1G 3Y6

Dear Mr. Nielson:

RE: MEMBERSHIP SERVICES

For many years MD Management Limited, a wholly owned subsidiary of the Canadian Medical Association, has provided investment vehicles exclusively for CMA members and their families. Initially these programs were related to RRSP legislation but, in the last decade, newer programs have been geared to the investment of after-tax savings. Our flagship fund has been MD Growth Investments Limited, an internationally invested equity fund that has been the top performing fund in Canada over the past ten years.

A number of factors have suggested that we should look at the creation of a new equity mutual fund and expand the participation base of one of our existing funds. MD Growth now has assets in excess of $\frac{1}{2}$ billion dollars and our MD Management Board has approved in principle the creation of a new smaller look-alike mutual fund to be invested on an international basis. The Templeton group, who currently manage MD Growth, would be the major investment advisor. As well our MD Realty Fund, with assets of over \$40 million, could benefit from increased investment in order to invest in larger real estate properties.

One approach is to market the Realty Fund and the MD Growth look-alike fund directly to the public through the brokerage community. A front-end charge of 5% would be paid as a commission and \$95 out of each \$100 paid would be invested in the Fund. In addition, an annual management and administration fee of $1\frac{1}{2}\%$ would be charged against the Fund.

MAJ 5 1986

May 2, 1986

Another approach, or possibly a combined approach, would be to involve the major professional associations who may be interested in utilizing these mutual funds as a benefit of membership within their association. The funds would not be competitive with RRSP products which your Association may currently use. In the suggested combined approach, the 5% commission charge would not be levied for those of your members who joined the funds through your association. Thus 100% of the amount contributed by your members would be invested on their behalf. In addition, we would be prepared to pay to your association $\frac{1}{4}$ of one percent per year of the accumulating value of your members' investments in these funds. Such payments would be remitted to you on a quarterly basis.

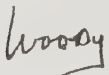
For this payment we would ask you to provide ongoing support for our marketing efforts. This would include the provision of membership lists, address updates and a broad-based endorsement of the concept as a whole. Given a certain level of participation, representation on the Fund's Board of Directors would also be possible.

The Board of Directors has asked me to approach you and the other major professional associations to determine whether you would be interested in utilizing these funds as a membership benefit for your group.

For your information we are enclosing current brochures on MD Growth and MD Realty Funds. I realize that this is an entirely new concept and that you will want to discuss this proposal with your officers and members of your staff. We would be pleased to provide any additional information you require and would undertake to arrange meetings at staff or Board level if this would be helpful to you.

Yours sincerely

THE CANADIAN MEDICAL ASSOCIATION



B.E. Freamo
Secretary General

Enclosure



CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

1815 ALTA VISTA DRIVE, OTTAWA, ONTARIO, CANADA K1G 3Y6
TELEPHONE (613) 523-1770

OFFICE OF THE PRESIDENT

SCHEDULEPRESIDENT - CANADIAN DENTAL ASSOCIATIONDR. B. W. HOLMES1985

Oct. 2	Presidents & CEO's Annual	Ottawa
Oct. 3-4	Annual CDA Bd. of Govs.	Ottawa
Oct. 4	Executive Council	Ottawa
Oct. 5	CDSPI Board/Annual	Ottawa
Oct. 16	Toronto All Societies	Toronto
Oct. 17	Provincial Dental Directors	Quebec City
Oct. 18-19	Manpower Symposium	Toronto
Oct. 23	Meeting Manifest	Toronto
Oct. 24	U. of T. Info. Night	Toronto
Oct. 25-26	Society Meeting	Dryden
Oct. 28	CDSPI	Toronto
Nov. 2-6	American Dental Assoc.	San Francisco
Nov. 14-15	Management Committee	Ottawa
Nov. 16-18	Executive Council/Retreat	Deerhurst
Nov. 18	CDA/CDSPI Mgt.	Willowdale
Nov. 19	Meeting Mr. Nicholson/Obonsawin	Ottawa
	Health & Welfare	
Nov. 19	Stratford Society Meeting	Stratford
Nov. 28	Toronto Academy Winter Clinic	Toronto
Nov. 29-30	ODA Board	Toronto
Nov. 30	Opening Ceremony, New Wing, Faculty of Dentistry U of T	Toronto
Dec. 5	Meeting Rep. Sask. College	Toronto
Dec. 6	Meeting Nfld. Dental Rep.	Toronto
Dec. 6	Conf. of Prov. Licensing Bodies	Toronto
Dec. 7	Membership Committee	Ottawa

PRESIDENT'S SCHEDULE - CONTINUED

1986

Jan. 16-18	Manitoba Annual	
Jan. 24	Meeting-Medical Services	Ottawa
Jan. 25	Manpower Committee	Ottawa
Jan. 28	Health Services & Promotion Br.	Ottawa
Feb. 11	Vancouver & District Dental Society 1986 General Meeting	Vancouve
Feb. 19-20	Management Committee	Ottawa
Feb. 21-22	Executive Council	Ottawa
Feb. 24	McGill Welcome/Prof.	Montreal
Feb. 24-25	PreLicensure Conf.	Montreal
Feb. 28	Exec. Meeting-FDI 1993	Vancouver
Mar. 1	University of Alberta	Edmonton
Mar. 3-5	B.C. College Convention	Vancouver
March 21-22	At.Provs. Exec.	Halifax
April 2	Call the President Day	Ottawa
April 3	Annual Specialty Meeting	Ottawa
April 4-5	Interim Board of Govs.	Ottawa
April 19	PEI Annual	Charlottetown
April 25	Grad Reception U of Man.	Winnipeg
May 2	Kenora Society Meeting	Miniaki
May 9-10	ODA Board	Toronto
May 10	New Brunswick Annual	Moncton
May 11	CDSPI/ODA/CDA	Toronto
May 11-14	ODA Convention	Toronto
May 14	CDA/AGD-CB	Toronto
May 24-27	Can. Pharmaceutical	Montreal
May 25-29	Les Journées dentaire	Montreal
May 27	McGill Breakfast	Montreal
May 28	Meeting Min. H&W Can.	Ottawa
May 30	U of T Grad. Lunch	Toronto
May 31	PRUC	Ottawa
June 5-7	College of Dental Surgeons of Sask. Convention	Swift Current
June 13	Nova Scotia Convention	Halifax
June 25-26	Management Committee	Ottawa
June 27-28	Executive Council	Ottawa
July 30-Aug.2	Alberta Convention	Grande Centre

PRESIDENT'S SCHEDULE - CONTINUED

August 11-12	CMA Gen. Council	Winnipeg*
August 7-8	CFDS Grad Ceremony	Borden
Aug. 15-16	Atlantic Pro. Exec.	Charlottetown
August 21	Presidents & CEO's	Halifax
August 22-23	CDA Annual Board	Halifax
August 24-27	CDA Convention	Halifax

Rev. 1/86

*Tentative

COUNCIL ON CONSTITUTION & BY-LAWS

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

MEMBERS: Dr. G.H. Peacock, Saskatoon - Chairman
 Dr. M.J. Crompton, Moncton
 Dr. B. Jackson, Kitchener
 Dr. M.J. Leitch, Kelowna
 Dr. E.F. Allison, Calgary - Executive Liaison

1. Council Meetings

Since the 1986 Interim Meeting of the Board of Governors, no formal meeting of the Council has taken place; rather, all items requiring attention were handled through written correspondence.

2. Items Requiring Board Action

1. At the 1986 Interim Meeting of the Canadian Dental Association Board of Governors, direction was given to your Council to undertake revisions to the current Constitution and By-Laws of the Canadian Dental Association.

2. In accordance with the directions of the Board, your Council recommends:

(a) With respect to Motion 86.15

RESOLVED:

86.68 THAT Article V, Section 6 - Student Membership be amended as appended.

ADOPTED

APPENDIX A

(b) With respect to Motion 86.12

RESOLVED:

86.69 THAT Article VIII, Section 15 be amended as appended.

ADOPTED

APPENDIX B

COUNCIL ON CONSTITUTION & BY-LAWS

RESOLVED:

86.70 THAT Article IX, Section 7 be amended as
 appended.

ADOPTED

APPENDIX C

RESOLVED:

86.71 THAT Article IX, Section 8 and 9 be deleted,
 and further

ADOPTED

RESOLVED:

86.72 THAT Article IX, Section 10 be renumbered as
 the new Section 8.

ADOPTED

APPENDIX D

RESOLVED:

86.73 THAT Article XI, Section 2 be amended as
 appended.

ADOPTED

APPENDIX E

RESOLVED:

86.74 THAT Article XI, Section 3 be amended as
 appended.

ADOPTED

APPENDIX F

COUNCIL ON CONSTITUTION & BY-LAWS

RESOLVED:

- 86.75 THAT Article XI, Section 4 be amended as
 appended.

ADOPTED

APPENDIX G

RESOLVED:

- 86.76 THAT Article XI, Section 5 be amended as
 appended.

ADOPTED

APPENDIX H

RESOLVED:

- 86.77 THAT Article XI, Section 6 be amended as
 appended.

ADOPTED

APPENDIX I

- (c) With respect to the Board's direction that Article XI,
Section 4 (Appendix J) be amended, changes to certain
sections of Articles X and XVI are required. As a result, your
Council recommends:

RESOLVED:

- 86.78 THAT Article X, Section 4 be amended as
 appended.

ADOPTED

APPENDIX J

RESOLVED:

- 86.79 THAT Article X, Section 6 be amended as
 appended.

ADOPTED

APPENDIX K

COUNCIL ON CONSTITUTION & BY-LAWS

RESOLVED:

86.80 THAT Article XVI, Section 1 (a) be amended as appended.

ADOPTED

APPENDIX L

RESOLVED:

86.81 THAT Article XVI, Section 2 be amended as appended.

ADOPTED

APPENDIX M

RESOLVED:

86.82 THAT Article XVI, Section 4 (i) be amended as appended.

ADOPTED

APPENDIX N

3. Items for Information - Not Requiring Board Action

At the present time, your Council is considering the direction of the Board to examine the question of impeachment of a member of the Management Committee. It is anticipated that an opinion/recommendation will be available for consideration at the 1987 Interim Meeting.

Respectfully submitted,

G.H. Peacock, D.D.S.
Chairman, Council on
Constitution and By-Laws

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Constitution and By-Laws with appreciation.

CURRENT

ARTICLE V

Section 6 Student Members

Any undergraduate student in an accredited dental school in Canada who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

APPENDIX A

PROPOSED

ARTICLE V

Section 6 Student Members

Any undergraduate student in an accredited dental school in Canada, or any Canadian citizen who is a student in a CDA recognized Faculty of Dentistry outside Canada, who has been recommended for membership by the Council on Student Affairs, or, any graduate dentist otherwise eligible for an Active or Affiliate membership who has enrolled in a full academic year or more of advanced study in a university, or in a hospital program approved by the Association, shall be granted Student Membership classification upon payment of the appropriate fee. All new graduates who have been student members in good standing of the Canadian Dental Association for the prescribed period shall be granted the status of an Active Member of the Canadian Dental Association from the date of graduation until December 31st of the year of graduation.

CURRENT

Section 15 Duties of the Chairman of the Board

- (a) to preside at meetings of the Board of Governors and perform such duties as custom and parliamentary usage require.
- (b) to appoint a secretary pro tem in the absence of the Secretary of the Board.
- (c) to appoint, with the consent of the Board of Governors, special committees to perform duties not otherwise assigned by By-laws, which special committees shall serve until adjournment of the session at which they were appointed.
- (d) to appoint scrutineers to assist in determining the result taken by vote of the Board of Governors.

The Chairman of the Board shall hold no other elective office in the Association while he is serving as Chairman of the Board.

APPENDIX B

PROPOSED

ARTICLE VIII

Section 15 Roles and Responsibilities of the Chairman of the Board of Governors

- (a) shall preside at meetings of the Board of Governors and perform such duties as custom and parliamentary usage require.
- (b) shall appoint a secretary pro tem in the absence of the Secretary to the Board, in consultation with Management Committee.
- (c) shall appoint scrutineers to assist in determining the result taken by vote of the Board of Governors.

The Chairman of the Board shall hold no other elective office in the Association while he is serving as Chairman of the Board.

CURRENT

ARTICLE IX

Section 7 Powers

The Executive Council shall conduct all business of the Association when the Board of Governors is not in session, subject to the Letters Patent, By-laws of the Association and the mandates of the Board of Governors.

- (a) The Executive Council shall have power to establish administration rules and regulations not inconsistent with these by-laws.
- (b) The Executive Council shall have power to direct the President to call a special session of the Board of Governors pursuant to Article VIII, Section 7.
- (c) The Executive Council shall have full discretionary powers to cause to be published in or omitted from any official publication of the Association, any article in whole or in part, except the editorials written or approved by the Editors.
- (d) The Executive Council shall have power to establish interim policies when the Board of Governors is not in session and where such policies in the discretion of the Executive Council are essential to the management of the Association, provided however that such policies must be reported to the members of the Board of Governors within fourteen (14) days of establishment thereof and presented by the Executive Council for review at the next following session of the Board of Governors.
- (e) The Executive Council shall have the right to elect Honorary members.
- (f) The time and manner of distribution of surplus funds to the members participating in insurance plans shall be determined by the Executive Council.
- (g) The Executive Council will authorize and approve all contracts, agreements or the disposition of funds relating to insurance and investment programmes.

CURRENT

ARTICLE IX

Section 7 Powers (cont'd)

- (h) The Executive Council will act as trustees for all insurance retention funds or surplus or reserve funds.

Section 8 Duties

It shall be the duty of the Executive Council

- (a) to supervise the maintenance of headquarters property owned or operated by the Association.
- (b) to appoint the Executive Director of the Association.
- (c) to determine the date and place for convening each annual meeting of the Association.
- (d) to approve all clinics and exhibits in line with policies established by the Board of Governors.
- (e) to cause to be bonded by a surety company all appointed officers and employees of the Association entrusted with Association funds.
- (f) to ensure all accounts of the Association are audited by a certified chartered accountant at least once a year.
- (g) to prepare a budget for carrying on the activities of the Association for each ensuing fiscal year.
- (h) to review reports prepared for presentation and make recommendations concerning each report to the Board of Governors.
- (i) to submit an annual report of the Executive Council activities to the Board of Governors and following each Executive Council meeting to submit a summary statement of the business of the meeting to the members of the Board of Governors.
- (j) to annually recommend to the President chairmen of the councils excluding Executive, Student Affairs and Nominations from among membership of the respective councils as elected by the Board of Governors.

CURRENT

Section 8 Duties (cont'd)

- (k) to perform such other duties as are prescribed in these By-laws.
- (l) to admit Associate, Affiliate and Supporting members pursuant to Article V, Section 3, 6 and 8, and to elect Honorary members pursuant to Article V, Section 4.
- (m) to grant awards from time to time in accordance with the guidelines established by the Board of Governors.

Section 9 Sessions

(a) Regular Session

The Executive Council shall hold at least four regular sessions in each year.

(b) Special Session

Special sessions of the Executive Council may be called at any time by the President. The President shall call a special session on request of a majority of Executive Council members. At least ten days' notice must be given to each member of the Executive Council in advance of such special session. The business of a special session shall be limited to that stated in the notice calling such session except by the unanimous consent of the members present and voting at such session.

PROPOSED

ARTICLE IX

Section 7 Roles and Responsibilities of the Executive Council

- (a) shall act on behalf of the Board of Governors establishing interim policies when the Board is not in session and where such action in the discretion of Executive Council is essential to the management of the Association, provided that such action must be reported to the Board within fourteen (14) days and presented by Executive Council for review at the next following session of the Board of Governors.
- (b) shall establish guidelines and policy related to the administration of the Association in consultation with the Executive Director.
- (c) shall have full discretionary powers to cause to be published in or omitted from any official publication of the Association, any article in whole or in part, except the editorials written or approved by the editors.
- (d) shall be the trustees of all funds, properties and other assets of the Association.
- (e) shall report to each meeting of the Board of Governors.
- (f) shall provide the recommended agenda for each Board of Governors meeting and shall review all reports prepared for presentation and make recommendations concerning each report.
- (g) shall perform such duties as may be designated by the Board of Governors or this by-law.
- (h) shall ensure that a Management Planning Process and Priorities are established and carried out for the Association.
- (i) shall provide Executive Liaison to all Councils and Committees as deemed necessary.
- (j) shall appoint the Executive Director of the Association.
- (k) shall determine the date and place for convening each annual and interim meeting of the Association.
- (l) shall approve all clinics and exhibits in line with policies established by the Board of Governors.

PROPOSED

ARTICLE IX

Section 7 Roles and Responsibilities of the Executive Council (cont'd)

- (m) shall cause to be bonded by a surety company all appointed officers and employees of the Association entrusted with Association funds.
- (n) shall ensure all accounts of the Association are audited by a certified chartered accountant at least once a year.
- (o) shall review the draft budget for carrying on the activities of the Association for each ensuing fiscal year and make recommendations on the budget to the Board of Governors.
- (p) shall submit a report of the Executive Council activities to each meeting of the Board of Governors and following each Executive Council meeting to submit a summary statement of the business of the meeting to the members of the Board of Governors.
- (q) shall annually recommend to the President, chairpersons of the councils except as exempt by the Constitution and By-Laws, from among membership of the respective council.
- (r) shall admit Affiliate and Supporting members pursuant to Article V, Section 3, 6 and 8 and to elect Honorary members pursuant to article V, Section 4, and Life Members according to Article V, Section 5.
- (s) shall grant awards from time to time in accordance with the guidelines established by the Board of Governors.
- (t) shall act as trustees for all insurance, retention funds, surplus and reserve funds and shall determine the time and manner of distribution to the members participating in insurance plans.
- (u) shall authorize and approve all contracts, agreements or the disposition of funds relating to insurance and investment programs.
- (v) shall have power to direct the President to call a special session of the Executive Council.
- (w) shall hold at least four regular sessions in each year.

CURRENT

ARTICLE IX

Section 10 Quorum

Six of the voting members of the Executive Council shall constitute a quorum and any question submitted to a meeting shall be determined by a majority of the votes cast of the members present. In the event of an equality of votes, the President or other member occupying the chair shall not have a second or deciding vote.

APPENDIX D

PROPOSED

ARTICLE IX

Section 8 Quorum

Six of the voting members of the Executive Council shall constitute a quorum and any question submitted to a meeting shall be determined by a majority of the votes cast of the members present. In the event of an equality of votes, the President or other member occupying the chair shall not have a second or deciding vote.

CURRENT

ARTICLE XI

Section 2 Duties of the President

It shall be the duty of the President:

- (a) to preside at all meetings of the Executive Council in accordance with recognized parliamentary usage.
- (b) to serve as an official representative of the Association in its contacts with government, civic, business and professional organizations for the purpose of advancing the objects and policies of the Association.
- (c) to serve as an ex-officio member of all councils of the Association.
- (d) to make a report at the annual meeting of the Board of Governors.
- (e) to make interim appointments in case of vacancies occurring in the Executive Council or in other councils.
- (f) to appoint special committees when considered necessary.
- (g) to call special sessions of the Executive Council.
- (h) to sign all official documents requiring his signature.
- (i) to delegate his responsibilities for appropriate reason when he is unable to fulfill same.
- (j) to perform such other duties as may be provided in these By-laws subject to Article IX, Section 6 and Section 8.
- (k) to succeed to the office of the Past-President.

PROPOSED**ARTICLE XI****Section 2 Roles and Responsibilities of the President**

- (a) shall be the Chief Elected Officer of the Association.
- (b) shall have the authority to act on behalf of the Executive Council and/or Board of Governors when necessary, in consultation with, and with the concurrence of, the majority of the membership of the Management Committee.
- (c) shall be the chief spokesperson of the Association.
- (d) shall be the Chairperson of the Executive Council and the Management Committee.
- (e) shall serve as ex-officio member of all councils and committees of the Association.
- (f) shall report to all meetings of the Board of Governors and Executive Council.
- (g) shall make interim appointments to fill vacancies existing in all Councils and Committees.
- (h) shall be responsible for appointing special committees when necessary, in consultation with, and with the concurrence of, the majority of the membership of the Management Committee.
- (i) shall be responsible for calling sessions of the Executive Council and the Board of Governors.
- (j) shall sign official documents when required.
- (k) shall delegate his responsibilities for appropriate action when he is unable to fulfill some.
- (l) shall perform such other duties as may be provided in these By-Laws subject to Article IX, Section 6 and Section 8.
- (m) shall succeed to the office of the Past-President.

CURRENT**ARTICLE XI****Section 3 Duties of the President-Elect**

It shall be the duty of the President-Elect:

- (a) to assist the President as requested in the performance of his duties.
- (b) to serve as Acting President in the event that the office of the President becomes vacant.
- (c) to act as Chairman of the Management Committee.
- (d) to succeed to the office of the President at the next annual meeting of the Board of Governors following his election as President-Elect.

PROPOSED

ARTICLE XI

Section 3 Roles and Responsibilities of the President-Elect

- (a) shall assist the President as requested in the performance of his duties.
- (b) shall serve as Acting President in the event that the office of the President becomes vacant.
- (c) shall be responsible for the preparation of the budget and presentation of the financial statements to the Executive Council and subsequently to the Board of Governors.
- (d) shall succeed to the office of the President at the next annual meeting of Board of Governors following election as President-Elect.

CURRENT

ARTICLE XI

Section 4 Duties of the Immediate Past-President

It shall be the duty of the Immediate Past-President:

- (a) to assist the President as requested, in the performance of his duties.
- (b) to act as Chairman of the Nominations Council.
- (c) to be a member of the Management Committee.
- (d) to act as Chairman of the Membership Committee (effective immediately after the annual Board of Governors' meeting).

PROPOSED

ARTICLE XI

Section 4 Roles and Responsibilities of the Immediate Past-President

- (a) shall assist the President as requested, in the performance of his duties.
- (b) shall act as Chairperson of the Council on Nominations, Awards and Trusts.
- (c) shall be a member of the Management Committee.
- (d) shall act as Chairperson of the Membership Committee (effective immediately after the annual Board of Governors' meeting).

CURRENT**ARTICLE XI****Section 5 Duties of the Executive Director**

The duties of the Executive Director shall be:

- (a) to act as executive head of the Association.
- (b) to engage all employees of the Association except as otherwise provided in these By-laws.
- (c) to co-ordinate the activities of the Executive Council and all councils of the Association.
- (d) to offer advice on all policy matters to the Board of Governors, other Councils and Committees of the Association.
- (e) to direct that the policies of the Board of Governors be implemented.
- (f) to draw on the resources of the Association in preparing assistance to the Board of Governors, other Councils and Committees of the Association.
- (g) to keep the records, minutes and be custodian of books, papers, documents and seal of the Association.
- (h) to pay all accounts and keep accurate record of receipts and disbursements.
- (i) to furnish a surety bond in amount determined by the Executive Council, the premium of which shall be paid by the Association.
- (j) to perform such other duties as usually appertain to this office or as may be designated by the Executive Council or these By-laws.

APPENDIX H

PROPOSED

ARTICLE XI

Section 5 Roles and Responsibilities of the Executive Director

- (a) shall be the Chief Executive Officer of the Association.
- (b) shall employ all staff of the Association, subject to budgetary, staffing and compensation policies established by the Board of Governors.
- (c) shall implement decisions made by the Executive Council and/or Board of Governors.
- (d) shall coordinate all activities of the Board of Governors, Councils and Committees of the Association.
- (e) shall offer advice on policy matters to the Board of Governors, other Councils and Committees of the Association.
- (f) shall draw on the resources of the Association in preparing assistance to the Board of Governors, other Councils and Committees of the Association.
- (g) shall keep the records and minutes and be custodian of books, papers, documents and seal of the Association.
- (h) Shall be custodian of all monies, securities, deeds and real property belonging to the Association.
- (i) shall cause to be paid all accounts and keep accurate records of receipts and disbursements.
- (j) shall furnish a personal surety bond in amount determined by the Executive Council, the premium of which shall be paid by the Association.
- (k) shall perform such other duties as usually appertain to this office or as may be designated by the Executive Council or these By-Laws.
- (l) shall supervise the maintenance of headquarters property owned or operated by the Association.
- (m) shall act as secretary to the Board of Governors.

CURRENT

ARTICLE XI

Section 6 Management Committee

The Management Committee shall be a committee of the Executive Council and shall consist of three members, the President, the Immediate Past-President and the President-Elect who shall be the chairman:

- (a) to serve as custodian of all monies, securities and deeds belonging to the Association.
- (b) to present an annual report to the Board of Governors including the Auditors' Report for the preceding year and the budget that has been proposed for the next succeeding fiscal year.
- (c) to perform such other duties as may be designated by the Executive Council or these By-laws.
- (d) to keep a minute book.

PROPOSED**ARTICLE XI****Section 6 Roles and Responsibilities of the Management Committee**

The Management Committee shall be a committee of the Executive Council and consist of three members, the Immediate Past-President, the President-Elect and the President who shall be the chairperson:

- (a) shall assure that all money securities, deeds and real property belonging to the Association are properly secured and accounted for.
- (b) shall provide advice to Executive Council on the Association's affairs.
- (c) shall perform such other duties as may be designated by the Executive Council or these By-Laws.
- (d) shall keep a Minute Book and report to the Executive Council.
- (e) shall review all budgets and financial statements presented by the President-Elect for the forthcoming year and the auditor's reports prior to presentation to the Executive Council and Board of Governors.

CURRENT

ARTICLE X

Section 4

The report presented by the Nominations Council shall be received in advance of the annual meeting by the Board of Governors and the complete list of names of proposed candidates shall be placed in nomination at the annual meeting.

PROPOSED

ARTICLE X

Section 4

The report presented by the **Council on Nominations, Awards and Trusts** shall be received in advance of the annual meeting by the Board of Governors and the complete list of names of proposed candidates shall be placed in nomination at the annual meeting.

CURRENT

ARTICLE X

Section 6

Nominations for a member of the Nominations Council for a term of three (3) years shall be made from the floor by a member or members of the Board of Governors.

PROPOSED

ARTICLE X

Section 6

Nominations for a member of the **Council on Nominations, Awards and Trusts** for a term of three (3) years shall be made from the floor by a member or members of the Board of Governors.

CURRENT

ARTICLE XVI

COUNCILS AND COMMITTEES

Section 1 Councils and Committees

(a) Councils

The Councils of the Association shall be

- Constitution and By-laws
- Dental Materials and Devices
- Education and Accreditation
- Ethics
- Health Care
- Hospital and Institutional Services
- Information Services
- Insurance and Investment
- Nominations
- Student Affairs

PROPOSED

ARTICLE XVI

COUNCILS AND COMMITTEES

Section 1 Councils and Committees

(a) Councils

The Councils of the Association shall be

Constitution and By-laws
Dental Materials and Devices
Education and Accreditation
Ethics
Health Care
Hospital and Institutional Services
Information Services
Insurance and Investment
Nominations, Awards and Trusts
Student Affairs

CURRENT

ARTICLE XVI

Section 2 Nomination and Election

- (a) Nominees for membership on councils shall be placed in nomination at the annual meeting of the Board of Governors.
- (b) All council members shall be elected or appointed by the Board of Governors at the annual meeting pursuant to Article XVI, Section 2(d) of these by-laws.
- (c) The Council on Nominations shall be nominated and elected by the Board of Governors at the annual meeting pursuant to Article X, Section 6 of these by-laws.

PROPOSED

ARTICLE XVI

Section 2 Nomination and Election

- (a) Nominees for membership on councils shall be placed in nomination at the annual meeting of the Board of Governors.
- (b) All council members shall be elected or appointed by the Board of Governors at the annual meeting pursuant to Article XVI, Section 2(d) of these by-laws.
- (c) The Council on Nominations, Awards and Trusts shall be nominated and elected by the Board of Governors at the annual meeting pursuant to Article X, Section 6 of these by-laws.

CURRENT

ARTICLE XVI

Section 4

(i) Council on Nominations

The Nominations Council shall consist of three members elected by the Board at its annual meeting pursuant to Article X, Section 6, of these By-laws, together with the Past-President, who shall be chairman. The membership should be geographically representative of the Association and should include one or more past-presidents.

It shall be the duty of the Nominations Council:

- (i) to prepare a list of all elective offices to be filled, excluding those for the Nominations Council, and submit this list ninety (90) days before the next annual session to members of the Board of Governors, council chairmen, presidents and secretaries of Corporate members, and presidents and secretaries of Sections.
- (ii) to invite, and receive in writing, nominations for each of the above elective offices. Nominations may be made only by members of the Board of Governors, council chairmen, presidents or secretaries of Corporate members, presidents or secretaries of Sections. Except in the case of nominations to the Nominations Council itself nominations from the floor during the annual meetings will not be valid unless there are withdrawals from the list of nominations as presented by the Council on Nominations. The Board may then make further nominations from the floor.
- (iii) to rule on the eligibility of the nominees in accordance with Articles IX and X.
- (iv) to make further nominations to ensure that there is at least one eligible nominee for each vacancy. The Nominations Council shall not make nominations as to its own membership as provided in Article X, Section 6 of these By-laws.

CURRENT

ARTICLE XVI

Section 4

(i) Council on Nominations (cont'd)

- (v) to submit an annual report, listing alphabetically all eligible nominees for each open elective office. The annual report is to be included with other council reports for advance distribution prior to the annual meeting.

PROPOSED

ARTICLE XVI

Section 4

(i) Council on Nominations, Awards and Trusts

The Nominations, Awards and Trusts Council shall consist of three members elected by the Board at its annual meeting pursuant to Article X, Section 6, of these By-laws, together with the Immediate Past-President, who shall be chairman. The membership should be geographically representative of the Association and should include one or more past-presidents.

It shall be the duty of the Nominations, Awards and Trusts Council:

- (i) to prepare a list of all elective offices to be filled, excluding those for the Nominations, Awards and Trusts Council, and submit this list ninety (90) days before the next annual session to members of the Board of Governors, council chairmen, presidents and secretaries of Corporate members, and presidents and secretaries of Sections.
- (ii) to invite, and receive in writing, nominations for each of the above elective offices. Nominations may be made only by members of the Board of Governors, council chairmen, presidents or secretaries of Corporate members, presidents or secretaries of Sections. Except in the case of nominations to the Nominations, Awards and Trusts Council itself nominations from the floor during the annual meetings will not be valid unless there are withdrawals from the list of nominations as presented by the Council on Nominations, Awards and Trusts. The Board may then make further nominations from the floor.
- (iii) to rule on the eligibility of the nominees in accordance with Articles IX and X.
- (iv) to make further nominations to ensure that there is at least one eligible nominee for each vacancy. The Nominations, Awards and Trusts Council shall not make nominations as to its own membership as provided in Article X, Section 6 of these By-laws.

PROPOSED**ARTICLE XVI****Section 4**

- (i) **Council on Nominations, Awards and Trusts (cont'd)**
 - (v) to submit an annual report, listing alphabetically all eligible nominees for each open elective office. The annual report is to be included with other council reports for advance distribution prior to the annual meeting.
 - (vi) to administer, publicise and report to the Executive Council and the Board of Governors on all aspects of Canadian Dental Association Trust Funds.
 - (vii) to administer, and report to the Executive Council and the Board of Governors on all matters relating to Canadian Dental Association Honours and Awards.

DENTAL MATERIALS & DEVICES

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Council Members:	Dr. R.Y. Barolet, Québec, Chairman, Dr. P.C. Desautels, Québec Dr. L.N. Johnson, Ontario Dr. D.W. Jones, Nova Scotia Dr. S. Newman, Alberta Dr. R.H. Roydhouse, British Columbia, Dr. D.C. Smith, Ontario Dr. P.T. Williams, Manitoba
Executive Liaison:	Dr. J. Christie, Nova Scotia

1. Council Meeting

One meeting took place at the Ottawa headquarters on May 23, 1986 since the last report to the 1986 Interim Board of Governors meeting held in March 1986.

Items for Information - Not Requiring Board Action

2. CDRF Award

A meeting has been held with CFDE's Chairman, Dr. Fred Reid, to explore possible additional funding in an effort to improve and generate more interest in the CDRF Award. CFDE will formally consider a written request in this regard, but legal impediments may preclude the possibility of regular and ongoing CFDE support.

Dr. Desautels reports that invitations for the 1987 award have been sent to 91 students, 42 from the 1985 graduates and 49 from 1986 graduates. CDA Journal (May 1986 issue) published an article written by Dr. Desautels highlighting this award. It is now awarded biennially, in the amount of \$2,000 and the winner is financially supported to attend the Convention to receive the award. If desired, the winner is also funded to attend the ACFD biennial meeting to present his paper. The list of student applicants is available for information.

3. Mercury Toxicity

The Council on Dental Materials reviews this subject at each of its meetings. As the Council members are in an excellent position to report on research initiatives across Canada, Council has not seen fit to change or qualify its previously stated position in this regard:

Council reviewed the available documentation and reaffirmed its conclusion that current research on the use of silver dental amalgam suggests that amalgam continues to demonstrate clear advantages in many applications over other restorative materials and that significant evidence of patient risk associated with its use has not been demonstrated. Most therapeutic materials involve potential side effects or risks as well as benefits and dentists are trained to be on their guard for these reactions at all times.

At the same time, Council recognizes increased patient interest in the topic and the need for references which can be made available to the patient. The CDA Journal has accordingly been asked to seek permission to reprint a March 1986 article, entitled "The Mercury Scare" from The Consumer Report. This is a balanced article which puts the subject of Mercury Toxicity in perspective and which has the additional credibility of appearing in a consumer publication. Dentists may find it a useful reference to present to patients.

4. CDA/CSA Certification Program

The Council on Dental Materials has reviewed the costs associated with the proposed CDA/CSA Certification Program and has not as yet seen fit to advise CDA administration to initiate the start up loan approved by the CDA Board of Directors. The most recent figures suggest that the certification cost-per-product may approach \$10,000, an amount that only large manufacturers would be able to pay. Consequently, the Council is reviewing the aims and objectives of the program and any alternative approaches that might meet them.

DENTAL MATERIALS & DEVICES

Page 3

4. CDA/CSA Certification Program - cont'd.

One alternative approach being investigated is the introduction, into the manufacturing process, of a quality assurance program incorporating specific standards and subject to external audit. Mr. Alf Dolan of Business Resource Group made a presentation to Council outlining how his firm could work with CDA in introducing quality assurance programs into the manufacturing process for dental materials. The appropriate dental standards are either published or under development (CSA Z349 series; ISO T/C 106). The quality standards which could be used for such a program are available within the CSA Z299 series. A system of voluntary registration with CDA would be established and those manufacturers co-operating in the process would receive documentation from BRG on the quality assurance process to be implemented. An initial CDA expenditure of \$6,000 would be required to develop the details of procedures and supporting documentation but on-going costs related to the introduction of the quality assurance program would be borne by the individual manufacturers co-operating in the program. There might be additional costs, depending upon CDA requirements for periodic external audit of manufacturers.

A further report will be presented to the next meeting of the CDA Board.

5. Use of Prophy-Jet

Council reviewed the use of the Prophy-Jet and it was felt that it is an effective device which should be used with appropriate precautions. The device employs a procedure which generates aerosols, and discussion of the fundamental problem of aerosols and infection control led Council to recommend that a microbiologist be approached, informally, to write an article on this topic. This is being done and further information will be presented in a future report.

DENTAL MATERIALS & DEVICES

Page 4

6. Wax-Recycling

Council notes with concern the fact that dental wax is being recycled by some technicians and that recycled dental wax may be available commercially. Recycling dental wax can cause the transmission of infection and recycling should not take place. A member of Council, Dr. R. Roydhouse, has agreed to prepare an article for publication in order to promote greater awareness of the dangers involved.

Respectfully submitted

R.Y. Barolet, Chairman,
Council on Dental Materials
& Devices.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Dental Materials and Devices with appreciation.

COUNCIL ON EDUCATION AND ACCREDITATION

REPORT TO THE ANNUAL CDA BOARD OF GOVERNORS MEETING AUGUST 1986

Members: Dr. A. Schwartz, Chairman, Manitoba
Dr. M.A. Boyd, British Columbia
Dr. G.W. Burgman, Ontario
Dr. M. Jahjah, Quebec
Dr. N.J. Layton, Nova Scotia
Ms. K. MacDonald, Nova Scotia
Dr. E.W. McIntyre, Alberta
Mrs. M. Paquin, British Columbia
Dr. K.F. Pownall, Ontario
Miss J. Robarts, Ontario
Dr. G.W. Thompson, Alberta
Dr. G.R. Thordarson, British Columbia

Alternate

Miss P. Zakarow, Ontario

ABSENT: Dr. G.S. Beagrie, British Columbia
Dr. D. Beck, British Columbia
Dr. H. Dick, Alberta
Dr. B. Graham, Nova Scotia
Dr. I. Vogan, Nova Scotia

Executive Liaison

Dr. R.J. Markey, British Columbia

ADA Representative

Dr. M. Santangelo, Chicago

Staff:

Mr. B.J. Henderson, Director of Accreditation
Miss L. Teteruck, Director of Educational Services
Mrs. L. Emmerson, Secretary to Council

Also in attendance were Dr. G. Kravis, Registrar, N.D.E.B.; Col. E.D. Cragg, C.F.D.S.S.; Dr. Ian Bennett, Halifax; Dr. K.C. Bentley, Montreal; Dr. R. Brooke, London; Mrs. Carole Worobey, CDHA; and Mr. P. Dykstra, Career Canada.

1. Council Meeting

The Council on Education and Accreditation met on June 25 and 26, 1986 in Ottawa. Immediately preceeding this meeting, Committee No. 1 met on June 24 and Committee No. 2 on June 23. The Closed Session of Council was held on the morning of June 25, with the remainder of time devoted to the Open Session.

COUNCIL ON EDUCATION AND ACCREDITATION

Committee No. 1 - Members Present

K.F. Pownall, Chairman, Toronto
P. Zakarow, London
N. Layton, Truro
E.W. McIntyre, Edmonton
G.R. Thordarson, Vancouver
G.W. Thompson, Edmonton

Committee No. 2 - Members Present

Ms. K. MacDonald, Chairman, Halifax
M.A. Boyd, Vancouver
G.W. Burgman, Kirkland Lake
M. Paquin, Vancouver
J. Robarts, Welland
G.R. Thordarson, Vancouver

Committee No. 3 - Dental Admissions Test Committee - Membership

M. Boyd, Chairman,
I.C. Bennett
J. Krupanszky
G.W. Thompson
A. Vaillancourt
D. Demarais, Consultant
J. Graham, Consultant
L. Graham, Consultant

Continuing Education Committee - Membership

K.C. Bentley, Chairman
G. Beagrie
M. Jahjah
H. Dick
D. Chaytor
J. Robertson

COUNCIL ON EDUCATION AND ACCREDITATION

2. Items Requiring Board Action

(a)CDA Conference on Prelicensure

The Council on Education and Accreditation has received and considered the report on the CDA Conference on Prelicensure held in Montreal on February 24-25, 1986. Dean George Beagrie, Conference Chairman, has received and conveyed the following recommendations resulting from the Conference:

- i. That the Council on Education & Accreditation and the Council on Hospital Services of the Canadian Dental Association, the National Dental Examining Board, and the the Association of Canadian Faculties of Dentistry, in association with provincial licensing authorities, explore further the matter of prelicensure as part of an effort to review the entire dental education experience.
- ii. That governments, national and provincial authorities, be encouraged to extend practice residency programs, and also support a review and evaluation of the delivery of dental care to federal and provincial institutions.
- iii. That the licensing bodies investigate interprovincial and/or national implications of prelicensure.

RESOLVED:

- 86.83 THAT the Continuing Education Committee of the Council on Education and Accreditation monitor the actions being taken by various bodies as a result of the recommendations from the Prelicensure Conference held February 24-25, 1986 and assist further developments in this regard.

ADOPTED

(b) Ad Hoc Committee on Documentation

The report of the Ad Hoc Committee was received and the following resolutions were adopted by Council for recommendation to the Board of Governors:

COUNCIL ON EDUCATION AND ACCREDITATION

Items Requiring Board Action (cont'd.)

(b) Ad Hoc Committee on Documentation (cont'd.)

RESOLVED:

- 86.84 That the requirements for approval of a graduate/postgraduate program in Oral & Maxillofacial Surgery be approved.

ADOPTED

APP. I

The Ad Hoc Committee also presented the first draft of a survey questionnaire to be submitted in support of an accreditation survey for a Program Leading to a DDS/DMD Degree. The Council on Education and Accreditation has approved the draft, in principle, subject to revision required in response to a review of the document by DDS/DMD programs across Canada. Council also approved the document on Confidentiality in the Accreditation process, which was ratified by the CDA Board of Governors during the April Interim meeting, at the request of the Council of Hospital and Institutional Services.

Council also received and considered a report from the Ad Hoc Committee on "Evaluation of Educational Outcomes - A Pilot Project". The report is included as Appendix II of the report of the Council on Education and Accreditation. The report documents the growing need for the accreditation process to place increased emphasis on the product or the outcome of the educational process. It describes, in this context, the evolution of a pilot project evaluating educational outcomes in a clinical setting as part of the accreditation survey process. Such pilot studies were conducted during the accreditation survey visits to the Universities of Saskatchewan and Manitoba. The general approach employed and supporting documentation are also included in the report.

APP. II

RESOLVED:

- 86.85 That the Director of Accreditation introduce into the accreditation process, beginning in 1987-88, the system for evaluation of educational outcomes developed by means of pilot studies at the Universities of Saskatchewan and Manitoba.

ADOPTED

COUNCIL ON EDUCATION AND ACCREDITATION

(c) Self-Assessment/Education Pilot Project

APP. III

The CDA Board of Governors delegated to the Council on Education and Accreditation's Committee on Continuing Education the task of reviewing a proposal by the National Dental Examining Board to develop a confidential, voluntary program, of self-assessment and continuing education for dentists. A Working Group of the Committee on Continuing Education has prepared a proposal for a pilot project which would provide a systematic and integrated approach to individualized continuing education for dentists. The proposal, which has been reviewed and accepted by the full Continuing Education Committee, as well as the Council on Education and Accreditation, is included as Appendix III.

The proposal outlines a voluntary and confidential program which consists of 100 multiple choice questions based on information in articles or books published within the last five years. These items will be of a problem-solving nature involving patient situations and will contain worthwhile and appropriate knowledge to a dentist in general practice. Approximately 500 dentists across Canada, chosen on the basis of random sampling would be invited to participate and receive individual scores on subject matter, as well as an item-by-time comparison of individual performance with that of the group. Those participating would also receive a list of references or learning resources which would be valuable in remedying any areas of relative deficiency. Finally, a retesting program would allow participants to determine the effectiveness of the educational strategies followed. The proposal also includes provision for a questionnaire to participants to review their satisfaction with the self-assessment/education program.

RESOLVED:

86.86 That the CDA Board of Governors support the development of the Pilot Project of a voluntary self-assessment/education program as proposed by the Committee on Continuing Education of the CDA Council on Education and Accreditation, and

 THAT assurances of confidentiality be maintained,

 THAT CDA provide \$15,000 towards the total estimated cost of the project, on the condition that the remaining support be provided from N.D.E.B., C.F.D.E. and A.C.F.D., and

COUNCIL ON EDUCATION AND ACCREDITATION

Items Requiring Board Action (cont'd.)

(c) Self-Assessment/Education Pilot Project (cont'd.)

THAT the jointly sponsored pilot project be co-ordinated by the CDA Committee on Continuing Education.

ADOPTED

(d) Teaching Conference

The topic of the 1985 Teaching Conference, chaired by Dr. Michael Rennert, was "The Teaching of Orthodontics in the Undergraduate Program".

The Association of Canadian Faculties of Dentistry has recommended, and the Council on Education & Accreditation has accepted, a suggestion for the 1987 Teaching Conference:

RESOLVED:

- 86.87 THAT the topic of the 1987 Teaching Conference be "The Universities' Role in Dental Continuing Education" and that Dr. Douglas Chaytor be asked to be Chairman of this Conference.

ADOPTED

(e) Dental Admissions Test Committee

A very comprehensive report was received from the Chairman of the Committee, Dr. Marcia Boyd. Recommendations from the Committee were approved by the Council and the following are presented to the Board for approval:

RESOLVED:

- 86.88 THAT Dr. Alain Vaillancourt be appointed to serve a second three year term on the DAT Committee.

THAT the Director of the Division of Educational Measurement of the ADA be appointed as a consultant to the DAT Committee for a one year term.

Items Requiring Board Action (cont'd.)

(e) Dental Admissions Test Committee (cont'd.)

THAT Dr. J. Graham, American Dental Association, continue in the capacity of consultant to the DAT Interview Study for another year.

THAT Dr. Luis Branda be appointed as a consultant to the DAT Committee for a one year term for purposes of the Interview Study.

THAT the DAT Administration fee schedule be approved.

ADOPTED

(f) Proposed Academy of General Dentistry Certification Program

The Council on Education & Accreditation reviewed the subject of a proposed Academy of General Dentistry Certification Board and reiterated its support for the position statement, opposing such a development, previously forwarded to the CDA Board by Dr. K. Bentley in his capacity as Chairman of Council.

THAT the Council on Education and Accreditation reiterate its support for the draft CDA position opposing the concept of an Academy of General Dentistry Certification Board and encourage the CDA Board of Governors to adopt the position statement.

Refer to Executive Council Report for adoption of motion.

Items Requiring Board Action (cont'd.)

(g) Oral Medicine - Request for Specialty Status

RESOLVED:

86.89 THAT the Council on Education and Accreditation advise the CDA Board of Governors that it does not support recognition of Oral Medicine as a Dental Specialty at this time.

 THAT the Continuing Education Committee of the Council on Education and Accreditation be asked to develop the concept of an umbrella discipline of diagnostic sciences within which concentrations in oral pathology, oral medicine and oral radiology might be possible.

ADOPTED

(h) Dental Hygiene Certification Examination

Council learned of informal discussion between the Canadian Dental Hygienists Association and the National Dental Examining Board of Canada with respect to the possible development of a national certification examination for hygienists. It was felt that the concept of such an examination warranted discussion in a forum including CDA representation.

RESOLVED:

86.90 THAT the Board support CDA representation in tripartite (CDA, NDEB, CDHA) discussion of national certification examinations.

ADOPTED

COUNCIL ON EDUCATION AND ACCREDITATION

Items for Information - Not Requiring Board Action

3. (a) Competency Profiles for Dental Assisting and Dental Hygiene

At the Interim meeting of the CDA Board of Governors in April, preliminary drafts of Competency Profiles for Dental Assisting and Dental Hygiene were tabled for review. Comments have been received from most provinces and most of the commentary has been supportive both of the goal of establishing national positions and of the content of the draft documents. Concerns have been expressed by two provinces, however, and Council has established a sub-committee with representation from the latter to ensure that concerns are met before presentation of the documents to the Board for approval.

(b) Reciprocity

The American Dental Association Commission on Education & Accreditation expressed concern, during 1985, that graduates of accredited dental education programs in the United States were not being treated in exactly the same fashion as graduates of accredited dental education programs in Canada, for purposes of licensure in Canada. The CDA Council established a sub-committee on Reciprocity and asked it to prepare a detailed brief for submission to ADA. As part of this process, a questionnaire was distributed to dental educators, dental associations and licensing authorities across Canada. The brief was presented for approval to the CDA Executive Council prior to submission to ADA.

The brief was considered at the May 9th meeting of the ADA Council, which was attended by the Chairman of the CDA Council and the CDA Director of Accreditation. It was apparent that the brief responded to many of the questions which had arisen and ADA Council approved a resolution to continue the dialogue in this respect and endorsed the Canadian suggestion of a written agreement on Reciprocity.

(c) Ontario Educational Programs for Dental Hygienists

Council has concluded its examination of eleven community college programs in Ontario preparing dental hygienists. These programs are "flow-through" programs in which the first year program in Dental Assisting serves as a foundation for the Dental Hygiene year. Instruction in the first year is specially augmented, especially in the basic sciences, to provide such a foundation.

While all Ontario programs have now been accredited, the CDA Council has formally written to the Ontario Council of Regents to make note of two concerns which apply to all Ontario programs: (i) the compressed nature of the educational programs and (ii) some problems in the interrelationship of the first and second year of these programs.

COUNCIL ON EDUCATION AND ACCREDITATION

Items for Information - Not Requiring Board Action

(c) Ontario Educational Programs for Dental Hygienists (cont'd.)

In March of this year, an observer from the American Dental Association attended the accreditation survey of the Confederation College Hygiene program in Thunder Bay. A subsequent report to the American Commission on Accreditation recorded the assessment that the CDA process of accreditation, as applied to these programs, employed standards and processes comparable to those utilized by ADA. Consequently, Community College Dental Hygiene programs in Ontario, if accredited, will be listed among programs recognized by the American Dental Association.

(d) Career Canada

The Council on Education and Accreditation reviewed a letter from a private educational firm named "Career Canada". Council has directed that the response to the letter indicate that it is possible, in the opinion of Council, for privately sponsored educational programs for dental auxiliaries to be eligible for accreditation, provided requirements are met.

(e) Reports

Council received reports from the following organizations, with thanks; (i) National Dental Examining Board of Canada, (ii) Royal College of Dentists of Canada, (iii) Association of Canadian Faculties of Dentistry, (iv) Canadian Dental Hygienists' Association, (v) Canadian Dental Assistants' Association, (vi) Council on Student Affairs, (vii) Canadian Fund For Dental Education.

(f) Surveys

A list of institutions requiring surveys of their programs during the 1985-1986 academic year was received and approved.

Survey Programs 1985-1986

Programs were accredited as follows:

McGill University DDS/DMD
McGill University Oral Surgery
Multidisciplinary Program Montreal General
Hospital Residency
Multidisciplinary Program Jewish General
Hospital Residency
Multidisciplinary Program Royal Victoria
Hospital Residency

Items For Information - Not Requiring Board Action (cont'd.)

Survey Programs 1985-1986

University of Manitoba DDS/DMD
University of Manitoba Oral Surgery
University of Manitoba Periodontics
University of Manitoba Orthodontics
University of Manitoba Dental Hygiene

University of Toronto Oral Surgery
University of Toronto Oral Pathology
University of Toronto Orthodontics
University of Toronto Pediatric Dentistry
University of Toronto Periodontics
University of Toronto Oral Radiology

Algonquin College of A.A. & T, Ottawa - Dental
Assisting/Dental Hygiene
George Brown College, Toronto - Dental
Assisting/Dental Hygiene
Seneca College, Toronto, - Dental Assisting/
Dental Hygiene
Cambrian College of A.A. & T., Sudbury - Dental
Hygiene
Confederation College of A.A. & T., Thunder Bay -
Dental Assisting/Dental Hygiene
Fanshawe College of A.A. & T., London - Dental
Assisting/Dental Hygiene
Georgian College of A.A. & T., Orillia - Dental
Assisting/Dental Hygiene
Niagara College of A.A. & T., Welland - Dental
Assisting/Dental Hygiene
Open Learning Institute, Richmond, B.C. - Dental
Assisting
Douglas College, New Westminster, B.C., - Dental
Assisting

(g) Nominating Committee Report

The following Committee membership is proposed for 1986-87.

1. Council Members

Dr. A. Schwartz, Chairman, Manitoba
Dr. G. S. Beagrie, British Columbia
Dr. M.A. Boyd, British Columbia
Dr. G.W. Burgman, Ontario
Dr. H. Dick, Edmonton
Dr. B. Graham, Nova Scotia
Dr. M. Jahjah, Quebec

COUNCIL ON EDUCATION AND ACCREDITATION

Items For Information - Not Requiring Board Action (cont'd.)

(g) Nominating Committee Report (cont'd.)

Dr. F. A. La Bounty, British Columbia*
Ms. K. MacDonald, Nova Scotia
Dr. E.W. McIntyre, Alberta
Mrs. M. Paquin, British Columbia
Dr. K.F. Pownall, Ontario
Miss J. Robarts, Ontario
Dr. G.W. Thompson, Alberta
Dr. G.R. Thordarson, British Columbia
Dr. I. Vogan, Nova Scotia
Student Council Representative*

2. DAT Committee

I. Bennett, Chairman, Halifax
M. Boyd
J. Krupanszky
G.W. Thompson
A. Vaillancourt*

3. Documentation Committee

K. Bentley, Chairman, Montreal
M. Boyd, Vancouver
R. Brooke, London*

5. Summary

Council continues to recognize and carry out its responsibilities related to education and accreditation. Council notes with regret that Dr. Norman Layton and Dr. Dan Beck will be leaving Council at the end of this term and expresses thanks and appreciation to each.

Respectfully submitted,

A. Schwartz, Chairman
Council on Education and
Accreditation.

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Education and Accreditation with appreciation.

REQUIREMENTS FOR APPROVAL OF A GRADUATE/POSTGRADUATE PROGRAM IN ORAL & MAXILLOFACIAL SURGERY

The Council on Education and Accreditation of the Canadian Dental Association is dedicated to the objective of developing and improving graduate/postgraduate education in the dental specialties in Canada to the highest possible level. The Council on Education and Accreditation reaffirms that in conducting evaluation surveys its prime purpose is to assist, stimulate and recommend methods and procedures that enable sponsoring institutions to improve the effectiveness of their programs. To this end Council considers the encouragement of sound educational experimentation and innovation to be an integral part of its accrediting responsibility. It is not the Council's intention to impose a system of regimentation which would lead to the standardization of educational programs in the specialty areas in Canadian dental schools.

This document delineates the minimum requirements for approval of a graduate/postgraduate program in oral and maxillofacial surgery. These requirements must be met for a program to be approved by Council on Education and Accreditation.

In addition, Council may undertake studies related to improvement of the accreditation process. These studies will require the provision of additional information by institutions being surveyed. Council expects the institutions to co-operate in these studies. Although not forming part of the minimum requirements at the time, the results of such studies may form the basis for the introduction of new minimum requirements in that area.

I. Definition of Terms

Must; Shall; Council expects; It is expected;

These words or phrases indicate a requirement that is essential or mandatory.

Should:

This word implies that a recommendation is highly desirable.

May or Could:

These words imply freedom or liberty to follow a suggested alternative.

Graduate Program:

One in which administrative responsibility for the program resides in the university's school of graduate studies.

I. Definition of Terms (cont'd.)

Postgraduate Program:

A planned sequence of courses, offered at universities, dental schools, associated teaching hospitals and/or other similar institutions designed to provide advanced educational experience, the successful completion of which is recognized by a diploma or certificate. Where institutional policy permits, it may lead to a degree in a professional field, e.g., Master of Dental Science or some similar designation, or it may form part of a more extensive program leading to a degree.

II. Oral & Maxillofacial Surgery

Oral & Maxillofacial Surgery is that branch of dental practice that deals with the diagnosis, treatment, prescribing for or operating upon any disease, injury, malformation or deficiency of the human jaws or associated structures

III. Scope and Duration of Educational Program

An educational program which would qualify a person for recognition as a specialist must, as a minimum, provide an educational experience of thirty-six months and should provide an educational experience of forty-eight months continuous advanced education which provides for a progressively graduated sequence of hospital experience together with a comprehensive study of the basic biological sciences as they relate to oral and maxillofacial surgery.

The institution must inform the prospective students of their professional responsibility to determine and to meet the licensure and specialty requirements for the geographic areas in which they plan to practice.

It is the candidate's responsibility to determine and to meet the licensure and specialty recognition requirements for the geographic area in which the candidate plans to practice.

IV. Areas To Be Assessed

(a) Program Goals & Objectives

Program self evaluation must be carried out on a periodic basis to determine if stated goals and objectives pertinent in the light of changing patterns of dental disease and dental practice are being met.

(b) Other Areas to be Assessed

The following areas will be assessed as they pertain to the stated program goals and objectives:

1. Institutional Relationships
2. Administration and Support
3. Physical Facilities
4. Faculty and Faculty Development
5. Research and Scholarly Activity
6. Admission Standards

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7. Curriculum
8. Evaluation Procedures
9. Clinic Administration
10. Preparation for Clinical Practice
11. Learning Resources
12. Student Affairs
13. Relationships with Dental Auxiliary Programs
14. Relationships with Hospitals and other Health Care Facilities
15. Relationships with DDS/DMD and other Health Science Programs
16. Relationships with Health Departments and Community Service Programs
17. Relationships with other Graduate/Postgraduate Programs
18. Relationships with Continuing Education Programs
19. Relationships with Dental Organizations and Licensing Bodies

1. Institutional Relationships

An advanced or dental specialty education program must be sponsored by a university which is properly chartered and licensed to operate and offer instruction leading to a degree, diploma or certificate. All other educational programs offered by the university eligible for accreditation by the Canadian Dental Association must be accredited. A hospital that provides a major component of an advanced dental education program must be approved by CCHA and must have its dental service accredited by the Council on Hospital and Institutional Services of the Canadian Dental Association. The hospital must also be affiliated with the respective university and a formal contract of affiliation should exist between university and hospital.

2. Administration and Support

Of particular interest to Council is the adequacy of the available financial support and management relative to the program's objectives. Administration and support staff must also be adequate. The continuity of this support must be demonstrated to ensure ongoing quality instruction and effective management. The parent institution should view, in a practical manner, the unique costs involved in dental education. The cost of dental clinic operations should be recognized by the university to be educational and, as such, not necessarily totally supported by clinic revenue.

When an affiliated institution is utilized for a part of the program the university is responsible for ensuring that educational objectives are achieved.

The sponsoring university's responsibility includes, but is not limited to, assuring an administrative system which is dedicated to education. Faculty of the program must be involved in selection of candidates, program planning and ongoing program review and evaluation.

The program should be a recognized entity within the university's administrative structure. The position of the program in the administrative structure should be consistent with that of other parallel programs and the administrator should have authority, responsibility and privileges comparable to those of other program administrators.

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The educational mission must not be compromised by a reliance on students to fulfill institutional service, teaching or research obligations. Resources and time must be provided for the proper achievement of educational objectives.

Student support through stipends, tuition remission, graduate assistant appointments or scholarships should be provided. Universities sponsoring advanced or dental specialty programs must provide financial support which will assure fulfillment of program objectives and accreditation requirements on a continuing basis. The budget should provide sufficient resources for innovations and changes which reflect current concepts of higher education and new developments in the practice of the specialty.

3. Physical Facilities

In surveying a program the Council will examine the type of building, the equipment of the classrooms, laboratories, clinics, hospital and institutional facilities and the general condition in which these are found. These will be viewed in light of current concepts and philosophies of dental practice and education. These facilities must permit effective attainment of the program objectives.

Space should be designated specifically for the program and the facilities should be supplied with modern equipment and instruments. Adequate radiographic and laboratory facilities must be available and in reasonable proximity to the patient treatment area. Students should be able to carry out part of their education in the hospital out-patient dental clinic, on the ward and in the operating room.

Where graduate/postgraduate programs are conducted at institutions which also have other programs it is expected that the demands for classroom, laboratory, seminar, library, clinical and other facilities will not compromise any individual program.

The design and construction of radiography facilities must provide adequate protection from ionizing radiation for patient, operator and others in close proximity. The institution must ensure that it is in compliance with provincial and federal regulations relating to radiation protection as delineated in the Guidelines for the Control of Radiation in the Dental Office* as developed by the Council on Health Care of the Canadian Dental Association. Where provincial or federal regulations are not in force it is the institution's responsibility to undertake inspection to ensure operation within safe parameters. There should be adequate space for students to mount, view and evaluate radiographs.

*Appendix I

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4. Faculty and Faculty Development

Both basic science and clinical faculty must have qualifications appropriate to their field of instruction. Such qualifications should include completion of advanced education programs, extensive clinical and/or teaching experience, research and other scholarly productivity, and peer recognition. A significant number of clinical staff should be certified specialists or possess comparable qualifications. The director of the program should possess advanced education in oral and maxillofacial surgery to qualify for a membership or fellowship in the Royal College of Dentists of Canada. Ideally the director should be a full-time faculty member as defined by the university.

Graduate/Postgraduate education must encourage independent study by the student. Continuous close supervision by the faculty is neither necessary nor desirable. However, it is expected that the faculty will be available to provide adequate supervision and guidance as the student requires. For this reason an adequate proportion of the faculty in Oral & Maxillofacial Surgery should be full-time and be readily accessible to the student. Graduate/Postgraduate programs must have at least one full-time faculty member who has advanced qualifications in oral and maxillofacial surgery comparable to those necessary for recognition as a specialist in the province in which the program is offered.

Student-teacher ratios must be adequate to meet the stated objectives of the program. Similarly the number of full-time faculty must be adequate to meet program requirements.

The relationship between and among individual faculty members and between faculty primarily engaged in research and teaching and those primarily engaged in administration must be such as to ensure the quality of the program.

The general and professional education of the faculty, their preparation and experience for clinical practice, teaching and research and their productive scholarship must be adequate to meet the stated objectives of the program. The number of faculty, teaching loads and administrative responsibilities will be examined in this context. The mechanism for appointment, review, reappointment and promotion of faculty members, including those with administrative positions, will be studied. Remuneration and benefits, tenure and security and methods for merit recognition will also be examined.

Terms of reference for faculty positions which clearly define responsibilities and privileges should be established and be made known to the faculty.

It is recognized that teaching in itself is a profession and professional education at the university level demands qualified persons who devote their careers to teaching and research. Appropriately qualified active practitioners also bring to the program a service and viewpoint which is essential and an appropriate number of such individuals must participate in the teaching program.

A mechanism should be in place for periodic review of all of a faculty member's responsibilities. In addition, students should have an opportunity to participate in the evaluation of teaching effectiveness.

The faculty, both full-time and part-time, must be involved in continuing their professional development, including continuing education in their own or related disciplines, as well as in-service and other training opportunities in order to develop increased expertise in their teaching, research and administrative roles as faculty members.

The Director must have sufficient authority and time to fulfill administrative and teaching responsibilities in order to achieve the educational goals of the program. In addition, it is the Director's responsibility to assure that students completing the program have achieved the standards of performance established for the program and for practice in the specialty.

The program faculty should have a strong interest in teaching and be willing to contribute the necessary time and effort to the educational program. A major portion of the specialty instruction and the supervision must be conducted by individuals who are educationally qualified in the discipline. In addition individuals who provide instruction and supervision specific to other specialty areas must be educationally qualified in their respective specialties.

5. Research and Scholarly Activity

There must be an appropriate commitment to research activity by the faculty teaching in the oral and maxillofacial surgery program. This responsibility should also involve students and should have the support of the parent university with respect to finances and facilities. An appropriate balance of faculty involvement between teaching and research must exist so that the quality of the program in oral and maxillofacial surgery is not compromised. Investigations leading to the improvement of the educational program should be included in such research activities.

Council believes that there are many worthy research projects, particularly of a clinical or educational nature, which could be undertaken without major funding from external agencies.

6. Admission Standards

Admission must be based on specific selection criteria which must be defined and be readily available to advisors and applicants. Academic performance should not be the sole criterion. Admissions committees should consider non-academic criteria in the over-all assessment of applicants for admission.

Candidates should be graduates from approved dental schools in Canada or the United States or possess the equivalent educational background. The applicant's academic standing must be such that it gives reasonable assurance of the successful completion of the program. It is suggested that several means be used to evaluate the applicant's qualifications. Among these are personal recommendations, interviews, national board results, academic records and, in the case of graduates whose first language is not the one of instruction of the institution, a language proficiency examination should be considered.

The university should have a stated policy concerning admission of advanced standing or transfer students and copies of this policy should be readily available.

It is recognized that students may transfer, with credit, from one accredited program to another, for a variety of reasons. An accredited program accepting such a transfer student must also clearly recognize an obligation to ensure that the student completes overall didactic and clinical preparation required. Programs must be able to demonstrate how they are assured that no aspect of clinical preparation, in particular, has been omitted or insufficiently emphasized.

7. Curriculum

Council will examine the curriculum with reference to the stated objectives of the program, what it seeks to accomplish for the student, the profession and the public and its success in realizing these objectives. It is the responsibility of the Institution to maintain under continuing review and amendment the curriculum of the graduate/postgraduate program in Oral & Maxillofacial Surgery. Council expects not only a well balanced curriculum but also one which recognizes changing patterns in the prevalence of dental disease, as well as in dental practice, through appropriately placed changes in specific areas of the graduate/postgraduate program in Oral & Maxillofacial Surgery.

By definition, a graduate/postgraduate program provides advanced education experience beyond the undergraduate level. It is expected therefore that courses will be taught at a greater depth and breadth than in the undergraduate curriculum. Where required for the purpose of improving the student's general background, a minimum number of undergraduate courses may be permitted as part of the program. Since graduate/postgraduate programs must emphasize independent study, the number of required formal courses should not be so excessive as to preclude the candidate from undertaking library work and other independent study.

Basic Sciences:

The objectives of instruction in the basic sciences must:

- (1) provide comprehension in greater scope and depth than achieved in undergraduate education with particular emphasis on fundamental principles and recent advances

- (2) emphasize the interrelationships among the basic sciences and to correlate them with clinical practice
- (3) develop the capacity for objective analysis and critical evaluation of scientific information.

Clinical Sciences:

The objectives of instruction in the clinical sciences must:

- (1) enhance the candidate's diagnostic acumen and clinical judgment in the diagnosis and planning of treatment for conditions more complex than those encountered in the undergraduate experience
- (2) provide advanced clinical experience beyond that usually required of the general practitioner in the management of conditions appropriate to the field of specialization
- (3) emphasize the need for basing clinical judgments on objective criteria in order to avoid any tendency toward unnecessary empiricism or dogmatism
- (4) ensure that treatment in the field of specialization is appropriately related to the dental and general needs of the patient

Although the basic sciences are taught in the undergraduate years, they are developing so rapidly that the student should be made aware of recent advances in order to understand better the biologic fundamentals of dental practice.

Basic science instruction should be designed to be relevant to the clinical management of the patient. The clinical program should include a variety of clinical experiences. Emphasis must be placed upon thoroughness of patient evaluation and accuracy in diagnosis. Experience should be acquired in the treatment of both routine and complex cases.

Consultation with teachers of other specialty areas of dental practice and offering of joint seminars should be encouraged. Assignment of students to other graduate/postgraduate clinics should be fostered so that they may observe modes of treatment related to their field. Observation of faculty in the private practice setting or in the operating room, is desirable.

Participation in teaching is a learning experience for the student as it enhances the ability to organize and evaluate material and communicate information to others. The student should be assigned to teach in the institution's programs and also encouraged to participate in table clinics, demonstrations or lectures before dental society meetings and study clubs. Participation as both clinician and student in the institution's continuing education program is also recommended. Other continuing education experiences are encouraged.

The program must ensure that the student participates in a research experience. The disciplined analysis involved in a clinical or laboratory research experience can be highly rewarding and can stimulate the intellectual curiosity of the students. While not every institution is prepared to offer extensive research facilities, a research experience need not be elaborate or costly.

The program must also ensure that the student is able to prepare a scientific paper suitable for publication.

The following list, although not exhaustive, represents those subjects which Council expects to find in an acceptable program. These subjects may be present with varying degrees of emphasis and need not necessarily be identified by a specific course title or name:

ESSENTIAL MATERIAL

A. Clinical

The trainee in oral surgery shall assume increasing responsibility for and become proficient in the following procedures throughout his training period.

1. Removal of normally and abnormally positioned teeth.
2. Management of trauma to the teeth, jaws and associated structures.
3. Management of significant pathological processes of the mouth, jaws and associated structures.
4. Management of congenital or acquired dentofacial and craniofacial deformities.
5. Experience in local and general anaesthesia. General anaesthesia training must be no less than three months duration and the trainee must be completely committed to the anaesthesia service to permit his active participation in all of the departmental teaching and clinical sessions. There must be adequate training in ambulatory out-patient anaesthesia.
6. Experience in the management of patients requiring intensive care.
7. Oral diagnosis and treatment planning with emphasis on the aspects most pertinent to oral surgery.
8. Physical diagnosis.
9. Understanding of imaging methods of the head and neck area and interpretation of results.

10. Off-service rotations should include medicine, orthopedics and/or general surgery, infectious diseases, emergency medicine and one or all of plastic surgery, otorhinolaryngology or head and neck surgery.

B. Didactic

The basic science program for oral surgery must include:

Anatomy, Microanatomy and Surgical Anatomy
General and Oral Pathology
Pharmacology
Clinical Biochemistry
Clinical Physiology
Clinical Microbiology
Clinical Laboratory Procedures

It is expected that the didactic program will bear direct relevance to, and complement, the required clinical skills, thereby providing a suitable theoretical base for the practice of oral surgery. In addition,

Diagnostic experience must be provided in research (clinical or basic science) and investigative procedures.

C. Supporting Material

Relevant supporting subjects should be taught throughout the program and should include any subjects deemed necessary. In particular, the following should be included regularly: seminars, case presentations, rounds, question tutorials, and library topic research.

ADDITIONAL REQUIREMENTS

D. Beds & Patient Census

The support of an oral surgery training program requires a minimum annual census of approximately fifteen hundred out-patients for each first year student and a census of approximately one hundred in-patients per second year student. In hospitals where beds are allocated to specific services, it is recommended that the oral surgery department must have an assignment of at least of four (and preferably six) service beds per final student. In hospitals where beds are unassigned, there must be adequate availability to provide for the recommended number of patient admissions.

E. Program Integration

The program should be so organized that the house staff will hold positions of increasing responsibility for the care and management of patients. Instruction must be sufficient to enable residents to undertake surgery under supervision, and to acquire the necessary skill and judgement ultimately to reach full responsibility for the operation and pre- and post-surgical management of the patient.

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The educational period must include a progressively graduated sequence of hospital experience and a comprehensive study of the clinical and the basic biological sciences as they relate to oral surgery. Affiliations may be developed where institutions have complementary resources which can be combined to advantage in developing an acceptable program.

When more than one hospital or teaching institution is involved each programs content as well as the integration of the overall program must remain the responsibility of the university offering the program.

The resident may have minor teaching responsibilities as experience increases. This valuable phase of the educational program must include conducting ward rounds. Lecturing to nurses, dental and medical students, and supervising the activities of other residents of the program may also be included.

The resident should also participate in clinical pathological conferences, tumour board meetings, surgical and medical grand rounds, and other interdepartmental teaching activities of the hospital.

8. Evaluation Procedures

(a) Student Evaluation

An effective and valid system of student evaluation must exist and be applied. Understandably these systems and techniques will vary from program to program. However, Council must be satisfied that these systems accurately establish the basis for judgments which will govern the promotion or graduation of the dental student concerned.

(b) Patient Care Evaluation

Clinical objectives, competency standards and evaluation procedures must be defined. These procedures must include the evaluation of the treatment process as well as the product of such treatment. Faculty supervision must be adequate to ensure that acceptable patient care standards are maintained.

Members of the clinical staff and students must participate in some form of clinical appraisal or dental audit on a regular basis.

(c) Record Data and Evaluation

The patient record system must include data, signature and authorized instructions for each patient contacted, medical and dental histories, results of examinations, diagnostic aids, consultations, diagnosis/problem list, integrated and comprehensive treatment planning (including estimated fee) details of treatment rendered, cost, completion, review and follow-up procedures.

Students must be evaluated on the accuracy and completeness of their record-keeping.

9. Clinic Administration

The clinical records of the teaching institution must be sufficiently comprehensive for teaching purposes. Appropriate follow-up of patients for longitudinal studies must be carried out and adequate records must be kept so that evaluation of therapeutic procedures is possible.

Equipment and supplies for use in managing medical emergencies must be readily accessible and functional. The use of ionizing radiation, nitrous oxide, mercury, drugs and other substances and techniques that might be hazardous to students, patients, staff and faculty must be judiciously and carefully monitored. Adequate measures must be in place to prevent the transmission of infection.

Policies and/or protocols must exist relating to:

1. Audit of Patient Care
2. Collection of Patient Fees
3. Consultative Protocols
4. Fire and Safety Procedures
5. Medical Emergency Procedures
6. Patient Follow-up for Longitudinal Studies
7. Patient Assignment
8. Patient Recall
9. Patient Records
10. Development, Approval and Revision of Patient Treatment Plan
11. Prevention of Disease Transmission
12. Professional Decorum
13. Technical Laboratory Support

Such policies and protocols must be available for the students, staff and faculty.

While in certain circumstances students may be required to provide some supplies, equipment and patients, teaching clinics must provide sufficient support staff, supplies, equipment and patients for the adequate teaching of the Oral & Maxillofacial Surgery program. In addition, necessary funding for the maintenance and updating of the clinic and eventual replacement of major equipment items must also be ensured.

Effective working relationships between the Program Director, the Clinic Director or comparable appointee and other administrators are essential. The Program Director must have access to relevant faculty policy and decision-making groups and should have appropriate committee appointments. The Program Director must establish and maintain effective working relationships with the administrators of pertinent affiliated institutions.

10. Preparation for Clinical Practice

A graduate of the program must be capable of meeting the dental Health needs of the public as a practitioner of the specialty of Oral & Maxillofacial Surgery. The student must be provided with sufficient opportunity for development of proficiency in the specialty of Oral & Maxillofacial Surgery. There must be a sufficient supply of patients requiring a wide variety of services in order to provide adequate clinical experience. Treatment of disadvantaged patients should also be included. Patient assignments must provide adequate clinical experience. Accordingly the student must be capable of the development and implementation of an integrated treatment plan for comprehensive patient care including consultation with dental specialists as required. Clinical experience must be such as to produce a graduate who can safely and competently render those services usually provided in the practice of Oral & Maxillofacial Surgery.

11. Learning Resources

The library is viewed as an important learning centre in the dental program. It must, whether established separately or within a combined library, be professionally administered and well housed. It should be convenient and accessible to both dental students and faculty during and after scheduled hours of instruction. Selected reference material should be readily available for students. In addition, in the clinic or the laboratory, selected reference material should be readily available for students. The staff of the resource centre must be sensitive and responsive to the teaching and research activities of the program. Council encourages expanded development and use of audiovisual material and modern techniques of information retrieval. It further encourages the faculty and the learning resources staff to promote student, staff and faculty awareness of the materials available for their use. In addition these resources should be available to the alumni and the profession at large.

12. Student Affairs

Accurate information on fees, special charges, scheduling and evaluation procedures must be made available. Records of student progress and accomplishments must be accurately maintained and treated as confidential information. Adequate measures must be in place to ensure fair judgment of the student's achievements relative to requirements for successful completion of the program.

Basic financial support and supplementary support for special activities such as research, scientific conferences and continuing education courses are desirable.

At regular intervals students should be afforded an opportunity for expression of opinion regarding the program and the instruction they receive.

13. Relationships with Dental Auxiliary Programs

To the extent that mutually beneficial activities can be developed, it is appropriate for co-operation to take place between programs in oral and maxillofacial surgery and dental auxiliary programs.

14. Relationships with Hospitals and Other Health Care Facilities

Dental Services of Hospitals utilized in advanced educational programs must be approved by the Canadian Dental Association Council on Hospital and Institutional Services.

15. Relationships with DDS/DMD and Other Health Science Programs

Activities that are mutually beneficial to the program in Oral & Maxillofacial Surgery and the DDS/DMD program and/or other health science programs may be developed and are encouraged.

16. Relationships with Health Departments and Community Service Programs.

Co-operation with health departments and community service programs should be sought to provide the student with an orientation to delivery of health care in the community, especially for groups with special needs such as geriatric, disabled and medically compromised patients.

17. Relationships with other Graduate/Postgraduate Programs

Mutually beneficial activities between and among graduate/postgraduate programs should be encouraged. Joint participation in selected basic science and clinical courses is encouraged. The joint management of patients is expected, where appropriate.

18. Relationships with Continuing Education Programs

Participation of students in pertinent continuing education programs is an excellent means of providing current knowledge in concentrated form. The development and presentation of material in continuing education courses should be an integral part of the preparation of the student for service to the profession and possible academic career.

19. Relationships with Dental Organizations and Licensing Bodies

Clinical faculty should be licensed in the province in which the program is located. Membership and participation in local, provincial and national organizations by faculty members should be encouraged as an example to students, an obligation to professionalism and an opportunity for information exchange. Student participation should also be encouraged as an active learning experience.

REPORT TO THE COUNCIL ON EDUCATION AND ACCREDITATIONEvaluation of Educational Outcomes - A Pilot ProjectIntroduction

Traditionally the emphasis of an accreditation survey has been the evaluation of the process of education and the means by which the program objectives are met. Recently, however, attention has been focused beyond the process of education to educational outcomes, outputs or results. The concern over this issue has been evidenced through statements made by several different but associated bodies in the United States. For example:

The Dental Accrediting Process, M.V. Santangelo, J. Dent. Educ., 45(8): 513-521, 1981.

"Although the basic thrust of accreditation has, in the past, been placed on evaluating the educational process, a more recent trend in accreditation is to increase emphasis on the product or the outcome of the educational process. There is little doubt that in a changing, increasingly complex society, accrediting agencies will be faced with conceptualizing, developing, and refining mechanisms for dealing with product, as well as process, evaluation.

Control of the Campus: A Report on the Governance of Higher Education
(Published by the Carnegie Foundation, 1982)

"Standards for specialized accreditation should focus on outcomes, and campus evaluations should be conducted with full respect for the overall mission of the institution." (pg.79)

Council on Post-Secondary Accreditation (COPA)

Provision D.4. states: "Examines and evaluates institutions or programs in relation to the operational goals of the total institution and to educational outcomes."

United States Department of Education (USDOE)

Criterion (b) (6) states: "It secures sufficient qualitative information regarding the institution or program which shows an ongoing program evaluation of outputs consistent with the educational goals of the institution or program."

The ongoing assessment of educational outcomes is certainly the responsibility of an individual program or institution, however, it is the responsibility of the accrediting agency to ensure that this assessment is carried out. Sufficient qualitative information must be presented to the survey team members in order that they can evaluate the process by which the institution assesses such educational outcomes. The survey team must also determine if these educational outcomes are consistent with the program's stated goals and objectives.

The Council on Education and Accreditation of the Canadian Dental Association at its June 1984 meeting decided to incorporate a more specific evaluation of educational outcomes in the accreditation survey by supporting a pilot project designed to evaluate clinical outcomes. This was to be conducted during an upcoming accreditation survey of a dental undergraduate program. Since that time, two DMD/DDS programs have participated in the pilot. The format and logistics were developed and modified by the Council's Ad Hoc Committee on Documentation based on the conduct and feedback of the two pilot studies.

Observations

The faculty, staff and students of both institutions have been extremely cooperative and ready to assist in every way. Despite the time constraints under which the pilot was being conducted, requests were met with exceptional willingness and efficiency. The overall perception of the team members was that the pilot project went very well and that students managed the situation with confidence and maturity.

Information gained during each pilot project has not been incorporated in any way into the accreditation survey report. However, feedback has been provided to the institution with respect to findings for each of the components.

The chart audit, student case presentations and diagnosis and treatment planning provided valuable information about the success of integration of didactic knowledge and preclinical education with clinical performance. It also facilitated the assessment of the quality and consistency of treatment planning and level of interdepartmental/interdisciplinary communication.

Pilot Project to Evaluate Educational Outcomes

As no other evaluation beyond that conducted by the educational institution is in place such as provincial or national licensing examinations, the pilot requires a different approach to the assessment of educational outcomes.

Consequently, the pilot project has evolved to include the following:

- 1) Random Chart Audit (Appendix I)
- 2) Selected Chart Audit (Appendix I)
- 3) An evaluation of treatment delivered through student case presentation and patient examination (Appendix II, III and IV)
- 4) Diagnosis and Treatment Planning (Appendix V & VI)
- 5) Structured observation in the clinic (Appendix VII)

These activities will be undertaken by members of the accreditation team:

- 1) the representative of the provincial licensing authority or the NDEB
- 2) the accreditation survey team clinician

All the guidelines and expectations will be provided in advance to the institution for their understanding and for planning purposes. In addition, following the survey, a questionnaire will be sent to solicit student feedback with regard to their involvement in the evaluation process (Appendix VII)

The following is a listing of other outcome measures that were considered but not tested in a pilot program at this time:

1. Provincial/National licensure examinations
2. Through examination of qualitative information regarding outcome measures (objectives should be stated in measurable terms).
3. Assessment of ongoing program evaluation of educational outcomes.
4. Evaluation of data on student attrition and repeat rates.
5. Evaluation of stated clinical and laboratory competencies.
6. Through assessment of the evaluation process.
7. A survey of graduates regarding their perception of preparedness and competence for practice.
8. Information for corporate or institutional employers of dentists regarding their perception of preparedness and competencies for practice.
9. An evaluation by the institution of its ability to achieve its own goals.
10. Information regarding graduates' performance from the respective College or Licensing Body.
11. In future, an assessment of the percentage of graduates satisfactorily in practice.

The suggestions listed above are just some of the ways in which educational outcomes can be measured.

The Ad Hoc Committee on Documentation of the Council on Education and Accreditation recommends that an assessment of outcome measures be incorporated into the accreditation process of the DDS/DMD program beginning in the fall of 1987. The assessment will be based on the following activities which may be modified in the future following review of further pilot activities and experiences in conducting such assessments.

Procedures

1. Random and Chart Audit

A random selection of 12 charts will be taken from the chart storage for evaluation using the guidelines presented.

2. Selected Chart Audit

The institution will be asked to select an additional 16 charts - 6 that represent completed cases, with a minimum of 12 patient visits consisting of a treatment mix in multiple disciplines; the other 10 charts representing patients who are in the process of treatment, again with a minimum of 12 patient visits. Charts of patients who are medically compromised (e.g. diabetes, angina, asthma, allergy, physical or emotional handicaps, etc.) should be included. Charts should represent a mix of treatment, not all within the same discipline, and not more than 25% of the charts should represent Pedodontics or Orthodontics. If charts of young patients are selected, they should be comprehensive care cases which include both Pedodontics and Orthodontics.

3. Student Case Presentations

Six students will be randomly selected to present a case for evaluation by the survey team members. Assessment will be done according to the guidelines appended. One half hour will be allotted for each of these case presentations. Calibration of the examiners will be undertaken and verified during the first case presentation. Further evaluation is accomplished in teams of two members.

4. Diagnosis and Treatment Planning

The faculty will be asked to prepare, in advance (2 - 3 weeks), a diagnosis and treatment plan with supporting diagnostic data for 10 or more patients that they feel would be appropriate for the program. Ten or more should be prepared to ensure that six are available on the appointed day. Each patient should require more than limited treatment, at least 10 procedures, and be willing to participate in this process. The faculty should prepare, in advance, any supporting diagnostic aids (study models, radiographs, specialty consultations, laboratory tests, consultation(s) with patient's physicians(s) etc) which would be provided to the student upon their request. Evaluation would include the appropriateness of these requests. These diagnoses and treatment plans should reflect the expectations and philosophy of the teaching program. These will be used as the evaluation measure.

At the time of the site visit, six students would be selected at random to participate. The students will be expected to make a diagnosis and formulate a treatment plan. The time required to complete the diagnosis and treatment plan would be estimated for the individual case by the faculty member who prepared the case. This estimated amount of time will be allocated to the student assigned to this patient for the completion of the activity. The treatment plan produced by the student and the diagnostic aids requested will be evaluated by comparison with the faculty standard.

5. Observation in the Clinic Setting

A more formal evaluation of the delivery of clinical treatment will be undertaken using a structured check-sheet for reference by those involved (Appendix VII). Evaluators will circulate freely on the clinic floor observing treatment delivery and questioning students with regard to their activities. In addition, students may be asked

to demonstrate preventive home care instruction to their patients and may be asked to demonstrate their knowledge with respect to medical emergencies.

6. Clinic Operation Relative to Educational Outcomes

In the past a series of questions were presented to the Clinic Director which addressed activities and mechanisms that would facilitate successful clinic outcomes for the student clinicians. These have now been incorporated into the documentation questionnaire for the accreditation survey. The responses to questions that relate to clinical outcomes will be evaluated by the Survey Team.

Modifications of this proposed process will be developed by the Ad Hoc Committee on Documentation as a result of experience in the process of evaluating outcome measures.

Respectfully submitted,

MAB/lrg

File Ref: RD/MB/PAPER; ACCRED/REP

Ad Hoc Committee on Documentation
K.C. Bentley, Chairman
I.C. Bennett
M.A. Boyd

CHART AUDIT CHECK LIST

Accreditation Visit, Clinical Pilot Project

1. Medical/Dental History, Oral Examination, Problem List and Diagnosis
 - present, thorough and complete
 - accuracy of charting and recording
 - contra indications or considerations for treatment
 - signed by faculty
2. Diagnostic Aids - Tests, Radiographs, Models etc.
 - required? appropriate? requested? completed? dated?
diagnostic quality?
3. Treatment Plan
 - recorded, signed, dated
 - approved by faculty and patient
 - appropriate plan considering patient and circumstances
 - consultations as necessary, requested and completed.
 - preventive component
 - sequencing of treatment appropriate
 - estimate of treatment fees
 - acceptance by patient (plan & fees) -signature
4. Clinical Treatment
 - frequency of visits
 - lack of frequency - why?, substantiated
 - daily documentation - e.g. treatment details, cancellations etc.
 - signed by student and faculty
5. Correlation of Completed Procedures with Treatment Plan
 - reconciliation of treatment plan & treatment delivered
 - if no, why? record of such
 - fees - collection, correct coding
6. Treatment
 - quality satisfactory/unsatisfactory (refer to evaluation system)
 - case completed? (comprehensive care - if not, why?)
 - recall or follow-up procedures

GUIDELINES FOR STUDENT CASE PRESENTATION

Accreditation Visit, Clinical Pilot Project

Study models, mounted or unmounted, should be included as appropriate

Students should be prepared to present and discuss their case in full with attention to the following:

1. Patient's name, age and chief complaint at time of presentation.
2. Summary of dental and medical histories including implications for dental treatment.
3. Findings at examination.
4. Problem list generated from complete examination.
5. Diagnosis.
6. Treatment Plan and its rationale.
7. Stage of treatment to date.
8. Prognosis.
9. A critique of treatment provided to date and retrospective evaluation of treatment procedures.

CLINICIAN GUIDELINES

STUDENT CASE PRESENTATION

Accreditation Visit, Clinical Pilot Project

SOME SUGGESTED QUESTIONS FOR THE CLINICIANS INVOLVED IN STUDENT CASE PRESENTATION

1. a) If you could begin this case again, what would you do differently?
b) Why?
2. a) What is the most important thing that you have learned from treating this case?
b) Why?
3. What do you think could/should have been done better in the management and treatment of this patient? Why?
4. Is there anything that we haven't discussed that you would like to add?

POTENTIAL QUESTIONS FOR THE PATIENT

1. What do you think has been the best part of your treatment?
2. With respect to your student clinician:
 - a) What do you think he/she does best?
 - b) Where do you feel that he or she could improve the most?

CLINICIAN EVALUATION OF
STUDENT CASE PRESENTATION

Accreditation Visit, Clinical Pilot Project

Study models, mounted or unmounted, should be included when available.

Students should be prepared to present and discuss their case in full with attention to the following:

1. Patient's name, age and chief complaint at time of presentation.
2. Summary of dental and medical histories including implication for dental treatment.
3. Findings at examination.
4. Problem list generated from complete examination.
5. Diagnosis.
6. Treatment Plan and its rationale.
7. Stage of treatment to date.
8. Prognosis.
9. A critique of treatment provided to date.

* Satisfactory
Unsatisfactory

File Ref: BOYD #2 ACCRED/SURV

GUIDELINES FOR FACULTYDIAGNOSIS AND TREATMENT PLANNING ACTIVITY

Accreditation Visit, Clinical Pilot Project

Introduction

This form of assessment of student performance (or outcomes measure) permits the faculty to establish the criteria to be used for evaluation. This reduces the risk of any "outside" judgement of what would be considered appropriate in diagnosis and treatment planning for senior students in that institution.

Description

Oral diagnosis/Oral Medicine Faculty are asked to prepare 6 patients in diagnosis and treatment planning. This should reflect faculty expectation of senior student performance at the time of accreditation (January, 1986).

Any supporting diagnostic information which would be required in order to establish a diagnosis and treatment plan should be collected or produced (e.g. study models, radiographs, etc.). These would be available for the students participating in this activity upon their specific request.

The diagnosis and treatment planning would have to be performed 2-3 weeks prior to the accreditation visit in order that the patients' status was not significantly altered between the time of faculty diagnosis and student diagnosis and treatment plan. Both an "ideal" treatment plan and a treatment plan appropriate to the patient's needs and desires should be developed and presented.

As the faculty diagnosis and treatment plan will be used as the evaluation criterion for the student activity, it should reflect both an ideal treatment plan and a modified treatment plan that takes into consideration patients' finances, needs, motivation, etc.

Faculty are asked to establish what would be considered a reasonable length of time required by the student for the diagnosis and treatment planning of the specific patient involved.

Example of Diagnostic AidsRadiographs

- selected radiographs
- full mouth series
- orthopan

Medical Information Test

- call to M.D.
- specific lab tests

Models

- unmounted study casts
- mounted/articulated models

File Ref: BOYD #2 ACCRED/SURV.10

DIAGNOSIS AND REATMENT PLANNING ACTIVITY

PATIENT NAME _____

CHART NO. _____

CHECKLIST OF DIAGANOSTIC AIDS

	REQUIRED (Faculty)	REQUESTED (Student)
<u>RADIOGRAPHS</u>		
(a) selected areas: e.g.	☐	☐
(b) full mouth series	☐	☐
(c) orthopan	☐	☐
<u>MODELS</u>		
(a) unmounted study casts	☐	☐
(b) articulated study models	☐	☐
<u>MEDICAL INFORMATION</u>		
(a) consultation with M.D.	☐	☐
(b) specific laboratory tests e.g.	☐	☐
<u>OTHERS</u>	☐	☐

STUDENT CLINICIAN'S DELIVERY OF PATIENT CARE

OBSERVATION CHECK LIST

Note any deviations or observed problems in:

1. Punctuality

Comment:

☐

2. Personal Grooming & Hygiene

Comment:

☐

3. Cubicle Organization

Comment:

☐

4. Preparedness for Treatment

Comment:

☐

5. Beginning Treatment Promptly

Comment:

☐

6. Sterile Techniques/Control of Disease Transmission

Comment:

☐

7. Understanding of Treatment Rationale

Comment:

☐

8. Understanding of Treatment Procedure

Comment:

☐

9. Control of Patient Care

Comment:

☐

10. Posture

Comment:

☐

11. Completion of Treatment in Appropriate Time Relative
to Procedures and Experience

Comment:

☐

12. Student/Patient Interaction

Comment:

☐

13. Student/Staff/Auxiliary Interaction

Comment:

☐

14. Peer Interaction

Comment:

☐

15. Faculty Interaction

Comment:

☐

16. Faculty Availability

Comment:

☐

17. Record Keeping

Comment:

☐

18. Attention to Health Hazards (radiation, mercury, etc)

Comment:

☐

19. Preventive Care Instruction

Comment:

☐

20. Emergency Procedures/Emergency Support

Comment:

☐

Other Comments and Observations

☐

MAB:lrg

File Ref: RD/MB/CORRES; PILOTPROJECT

CANADIAN DENTAL ASSOCIATION

CLINICAL PILOT

STUDENT QUESTIONNAIRE

1. Did you have enough information to allow you to prepare for the case presentation/diagnosis and treatment planning
Yes ☐
No ☐
Comment _____
2. Did you feel you were able to adequately present and discuss your case? (case presentation only)
Yes ☐
No ☐
Comment _____
3. Was the time allotted too short? ☐
 too long? ☐
 about right? ☐
Comment _____
4. Were the clinicians able to make you feel at ease? Yes ☐
 No ☐
Comment _____
5. Do you think the Accreditation process should be concerned with patient treatment in addition to curriculum? Yes ☐
 No ☐
Comment _____
6. If you were organizing these clinical activities how would you do it differently?
Comment _____

7. Other comments or suggestions...

PILOT PROJECT

A Systematic and Integrated Approach to Individualized Continuing Education for Dentists

Background

One of the essential characteristics of professionals is acceptance of personal responsibility for maintenance of the knowledge and skills required to provide optimum professional services to patients entrusted to their care. Clearly, individual dental practitioners who are responsible to themselves and their patients must continually monitor their abilities and seek out continuing education opportunities appropriate to the improvement of personal areas of weakness or to the expansion of their professional abilities in order to meet new needs.

In short, the individual professional is responsible for both **self-analysis**, in terms of adequacy of performance, and **self-instruction**, in terms of the selection and completion of appropriate educational courses or activities when these are required for updating or growth.

The professional associations and licensing bodies working with professionals also have specific responsibilities in this regard. Fundamentally, the professional bodies share a concern to ensure that members of the profession can obtain the assistance they need to discharge personal responsibilities for self-analysis and self-instruction. To varying degrees, they are also responsible for ensuring that the members of the profession actually meet their individual responsibilities for self-analysis and self-instruction. Finally, provincial governments carry an overall responsibility to ensure that the professional bodies are in fact discharging their obligations in this regard.

Professional Responsibility and Patient Care

Acceptance of responsibility for patient care is a weighty assignment that individual practitioners must always be able to demonstrate is being met within legal, ethical and professional parameters. The American Dental Association recently issued the following statement, involving a definition of primary care and the related responsibility of the dentist:

Pilot Project

"Primary dental care is the management, coordination, and/or delivery of services, by a dentist, to meet the patient's oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health. A primary dental provider is the dentist who accepts the professional responsibility for the treatment, management, and overall coordination of services to meet the patient's oral health needs consistent with the ADA Principles of Ethics and Code of Professional Conduct."

Challenges:

Individual professionals attempting to meet their responsibilities for self-analysis and self-instruction encounter a variety of challenges. First, how does one assess an area of difficulty or weakness? An individual practitioner may be employing out-dated techniques without being aware that new approaches have rendered particular procedures obsolete. In such circumstances, conscientious professionals may select continuing education opportunities related to their interests rather than their needs. Second, even if a dentist identifies an area where continuing education is required, how can he or she find an educational program that is both appropriate and convenient in terms of time and location? Continuing education offerings available locally may be unsuitable or inconvenient.

Individualized Assistance

Individualized assistance is required to meet such challenges. Dentists should have access to programs which can help them to review their developing practice against their professional strengths and identify areas for updating or growth. There should also be access to individualized learning resources appropriate to the dentist's individual needs. The pilot project on "A Systematic and Integrated Approach to Individualized Continuing Education for Dentists" will develop and evaluate a mechanism to provide such individualized assistance.

Pilot Project Goals

The pilot project is a means of developing a non-threatening self-assessment mechanism which can guide and stimulate the learner toward the proper educational offering to fulfill specific needs. According to Dr. Marvin E. Johnson, the former Director of Physician Credentials and Qualifications for the American Dental Association, "this assistance can lead to a more efficient use

Pilot Project

of learner time and help prevent the existence of unidentified areas of deficiency. This latter problem is increasingly important because of the rapid expansion of medical knowledge, diagnostic and management technologies, and the increasing professional accountability demanded by the public."

The specific goals of the project have accordingly been identified as follows:

1. To develop and evaluate a pilot mechanism which will assist licensed dentists to meet their individual responsibility for the maintenance of professional knowledge and skills.
2. To provide objective assessment, relevant to clinical practice, with components of need identification and a mechanism to improve identified deficits.
3. To provide individual participating dentists feedback on the effectiveness of their behaviour and initiatives (as undertaken in response to identified needs).

Feb. 1986

PROTOCOL

SELF-ASSESSMENT/EDUCATION PILOT PROJECT

THE PROGRAM - VOLUNTARY AND CONFIDENTIAL

Part I	Will consist of 100 multiple choice items based on information in articles or books published in the past five years. These items will be of a problem solving nature involving patient situations and will contain worthwhile and appropriate knowledge required of a dentist in general practice.
PART II & PART II Results	Will provide a re-assessment of the subject areas in Part I and allow the participants an opportunity to evaluate whether the educational strategies followed in response were effective.
SHORT FOLLOW-UP	Questionnaire to determine participants opinion of program.

April 1986

Proposed Timetable for Self-Assessment/Education Pilot Project

April-May/86	Request to Universities for sample questions, answers and literature references for pilot project.
April/86	Request to C.F.D.E. for financial support pending CDA Board approval.
June/86	Selection of test items.
August 1986	Request for funds from CDA Board
Sept. 1986	Letter canvassing random sampling of practitioners for participation.
October 1986	Replies back from practitioners
Mid-October 1986	Questionnaire - Part 1 of program mailed to participants.
Mid-November 1986	Return of Part 1 of program.
End December 1986	Analysis of replies mailed to participants
Mid-March 1987	Post-test - Part 11 mailing
April, 1987	Return of Part 11
May 1987	Analysis and mailing of post-test - Part 11 results
June 1987	Follow-up with participants as program evaluation. Review of pilot project parameters and preparation of report with recommendations for presentation to Council and co-operating Associations.

April/86

COUNCIL ON ETHICS

- 1 -

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Members: Dr. G.R. Thordarson, British Columbia, Chairman
Dr. W.G. Leggett, Ontario
Dr. M.A. Lasko, Manitoba
Dr. B.G. Saik, Alberta
Dr. G.G. Turner, Noval Scotia

Dr. E.F. Allison, Alberta, Executive Liaison

1. Council Meetings

Council has not met since the 1986 Interim Meeting of the Board of Governors.

As Chairman, I met with the Executive Council, June 27, 1986, at their invitation, to discuss the mandate and future direction of the Council on Ethics.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

2. Future Activities - Council on Ethics

Based on discussion and direction received from the Executive Council, June, 1986, the Council on Ethics will continue to deal with the various issues brought to the Board in September, 1984. In doing so, the following parameters will apply:

- a) The Council on Ethics will address only very specific and narrow issues that may arise with regard to the Code of Ethics or policies and guidelines that CDA should adopt. An example, which should be considered, is the freedom of choice of patients to attend the dentist of their choice.
- b) The Council should deal with most items by submitting opinions as information to the Board, not requiring Board action, but only as opinion on the various issues from the Council on Ethics. This would allow these issues to be addressed and to be kept on file at CDA for the use of those provinces that may find them helpful. An example would be a statement with regard to newsletters.

COUNCIL ON ETHICS

- c) As an ongoing function, Council will liaise with other Councils/Committees, e.g. Third Party Dental Plans Committee, Professional Resource Utilization Committee, and respond to questions that arise from provinces or other jurisdiction.

I will attempt to arrange a meeting with the Chairman of the Council on Ethics of the Canadian Medical Association. I understand that they, for a number of years, have dealt in a very effective manner, with various ethical concerns that are raised by the provinces and forwarded to the Council for opinion. These opinions are not presented to their governing Council as policies, but merely as help and direction for the provincial component organizations.

Respectfully submitted,

Dr. G.R. Thordarson, Chairman

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Ethics with appreciation.

Appreciation is extended to Dr. Thordarson for his service to CDA during his term of Chairman.

HEALTH CARE

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Council Members: Dr. A. Toeman, Montreal, Que., Chairman
Dr. W. Allen, Charlottetown, P.E.I.
Dr. T.D. Fantin, Trail, B.C.
Dr. Keith I. Hamilton, Saskatoon, Sask.
Mrs. Peggy Larder, CDHA
Miss Suzanne Mader, CDAA, Halifax, N.S.
Dr. G. McFarlane, Grand Falls, Nfld.
Col. P.R. McQueen, CFDS, Ottawa, Ontario
Dr. R.B. Porter, Antigonish, N.S.
Dr. J.C. Rooney, Riverview, N.B.
Dr. D.G. Sage, Woodstock, Ontario
Dr. Kenneth R. Skinner, Winnipeg, Manitoba
Dr. Donald E. Upton, Calgary, Alberta

Dr. W. Bedford, Sr. Consultant Dentistry,
Health & Welfare, Ottawa, Ontario

Executive Liaison: Brig.-Gen. J.N. Wright, Ottawa, Ontario

1. Council Meeting

One Executive Sub-Committee meeting, May 30, 1986 took place at the Ottawa headquarters since the last report to the 1986 Interim Board of Governors meeting held in March 1986.

Items Requiring Board Action

2. AIDS Recommendations

All comments and suggestions received were reviewed during a point by point consideration of the draft document. The revised Recommendations for the Dental Treatment of Acquired Immune Deficiency Syndrome (AIDS) Patients is appended.

APPENDIX I

Following input from Council members, corporate bodies and Dr. Hardie, as well as review of legal advice from Low Murchison, CDA legal counsel, the following recommendation was approved by Council:

HEALTH CARE

Page 2

RESOLVED:

- 86.91 THAT the revised "Recommendations For the Dental Treatment of Acquired Immune Deficiency Syndrome (AIDS) Patients" be approved as amended.

ADOPTED

3. Standard Referral Form

Further review and consideration of the proposed referral form for the use of general practitioners resulted in one minor addition to the draft previously circulated: "Re:" line following the heading "Consultation".

General practitioners have, over the years, produced many referral forms which have provided basic information to the attending specialist. The Council Executive Sub-Committee emphasizes that this form is a General Practitioner's form supplied from the GP's office to give basic information for the Specialist's benefit. A CDA pamphlet with an introduction and directions can be prepared to accompany the form. It is anticipated that the passage of this form by the Board, will provide smooth and factual transfer of information between the offices.

APPENDIX II

RESOLVED:

- 86.92 THAT the draft Standard Referral Form For General Practitioners recommended by Council on Health Care be approved as amended.

ADOPTED

It was suggested to further facilitate the efficient use of this form it should be reproduced on NCR paper in duplicate.

RESOLVED:

- 86.93** **THAT CDA investigate printing the Standard Referral Form (in NCR duplicate format) and undertaking distribution on a cost-recovery basis.**

ADOPTED

4. Sedation Guidelines

Following consideration of suggestions and comments received from corporate members and members of Council, changes were made to the draft document "CDA Guidelines for the Use of Nitrous Oxide in the Dental Office". The revised document is appended.

APPENDIX III

RESOLVED:

- 86.94** **THAT the document "Guidelines for Utilization of Nitrous Oxide Conscious Sedation in Dentistry" be approved.**

ADOPTED

5. Sugar in Medications

Following a general discussion it was the consensus of the Committee that sugar is neither necessary nor desirable as an ingredient in medications. The proposed Policy Statement on Sweeteners in Medication is appended.

APPENDIX IV

RESOLVED:

- 86.95** **THAT the "Policy Statement on Sweeteners in Medication" be adopted as presented.**

ADOPTED

Items for Information - Not Requiring Board Action6. Guidelines on Smoking

As directed by Executive Council, the Executive Sub-Committee of the Council on Health Care has pursued the establishment of a CDA position on the use of tobacco (including smokeless tobacco). A proposed Position on the Use of Tobacco Products is appended for consideration.

APPENDIX V

Resource persons have been consulted and reference material is being collected. Mr. O.D. Lewis, Chairman of the Canadian Council on Smoking and Health, helped identify the following areas of potential involvement by the Canadian Dental Association:

1. Develop a formal CDA position on the use of tobacco (including smokeless tobacco). This has been accepted as a priority. (See Appendix V.)
2. Develop a CDA position with respect to its own operation, including Councils, Committees, Annual Meetings, Conferences and administration and employees on CDA premises.

This is felt (at least in part) to be beyond the purview of the Council on Health Care. It is understood, for example, that Mr. Jardine Neilson, CDA Executive Director, has introduced, in consultation with CDA staff, the first phase of a two-phase policy which could ban smoking by employees at CDA headquarters following the introduction of the second phase.

The Executive Sub-Committee has drafted recommendations on smoking at CDA meetings and conferences, however. (See Appendix V.)

3. A CDA resource pamphlet for the dental profession. This will be pursued by our Council with a view to providing a useful reference for dentists establishing policy for their own offices.

7. ID Systems

The Council on Health Care will be following up, as suggested, on the issue of dental identification systems. Dr. Don Upton has been asked to assist Council in developing positions in this regard, taking into account the questions presented in Appendix VI.

APPENDIX VI

8. Health Screening Project

The report on the CDA Health Screening Project is presented as Appendix VII. By all accounts, this was a successful initiative which should be repeated at periodic intervals if funding is available. If CDA convention planners can find staff to co-ordinate local arrangements, the Council on Health Care can provide some general guidance on the basis of experience with the 1985 project.

APPENDIX VII

9. The New Council and Executive Sub-Committee Format

From the point of view of the Executive Sub-Committee, the new structure is working well. Members of the Board may be able to make their own assessment from the number of documents presented for review. The members of the full Council on Health Care have not had an opportunity to present their views on this subject, however, and a more complete report will be presented to the next meeting of the CDA Board.

Respectfully submitted,

Andrew Toeman,
Chairman,
Council on Health Care

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Health Care with appreciation.

RECOMMENDATIONS FOR THE DENTAL TREATMENT OF
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) PATIENTS

1. The dental team should be familiar with and always practice acceptable infection control procedures, and ensure that effective personal barrier protection is employed during the treatment of AIDS patients.
2. Dentists should be aware of the oral manifestations of AIDS and AIDS Related Complex (ARC), and be prepared to refer suspect patients for appropriate medical investigations.
3. Health and Welfare Canada has advised that there is no medical reason why AIDS patients should not be treated in the private dental office with appropriate precautions. However, as such patients are often hospitalized and may have many complicating medical problems. If they do, treatment in a hospital dental unit may be more appropriate.
4. Dental care for AIDS and symptomatic ARC patients should be given after consultation with the attending physician.
5. In the dental care of AIDS patients emphasis should be given to the maintenance of optimal oral hygiene. Since AIDS patients have compromised resistance, treatment should be done with appropriate antibiotic prophylaxis.
6. Symptomatic ARC patients may be offered comprehensive dental treatment with antibiotic cover where appropriate.
7. Asymptomatic but HTLV - III positive individuals may be treated using effective personal barriers as otherwise healthy patients.
8. AIDS is a reportable disease in several Canadian provinces.



**STANDARD DENTAL
REFERRAL FORM**

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

Dear Dr. _____

We are referring:

PATIENT: _____ BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: BUS. _____ RES. _____

REASON FOR REFERRAL:

☐ **CONSULTATION** RE: _____

☐ **TREATMENT** (as requested)

(Please provide specialist with appropriate details of problem, i.e. urgency, areas of concern, using F.D.I. tooth numbering system).

RELEVANT HISTORY:

(Indicate any special factors, either dental or medical, such as known allergies, specific medical problems relevant to diagnosis and treatment).

- | | |
|--|---|
| ☐ PLEASE CALL THE PATIENT | ☐ PLEASE REPORT -- WRITTEN |
| ☐ PATIENT WILL CALL | ☐ -- PHONE |
| ☐ AN APPOINTMENT HAS BEEN MADE | ☐ POST REFERRAL MAINTENANCE - ☐ BY SPECIALIST |
| | ☐ IN THIS OFFICE |
| ☐ RADIOGRAPHS ENCLOSED | ☐ TO BE DISCUSSED |
| ☐ PLEASE RETURN RADIOGRAPHS AFTER USE | ☐ OTHER RECORDS AVAILABLE |
| ☐ NOTIFY ON COMPLETION | |

DATE _____

DRAFT

**GUIDELINES FOR UTILIZATION OF NITROUS OXIDE-OXYGEN
CONSCIOUS SEDATION IN DENTISTRY**

A. Clarification of Terms

In order to reflect the current approved, taught and recognized use of nitrous oxide in dentistry, official literature and communications should refer to the technique as "nitrous oxide and oxygen conscious sedation". The term "analgesia" implies an inappropriate use of this drug.

B. Legal Responsibilities

1. Training in the use of nitrous oxide and oxygen conscious sedation must be mandatory.

C. Course Requirements

1. Courses approved by the CDA must:
 - (a) be taught by dentists or physicians with formal training and experience in all areas of anaesthesia and sedation as they apply to dentistry;
 - (b) be held in a properly equipped dental office environment or institution in order to permit a significant portion of such a course to deal with candidate participation and utilization of the techniques on patients;
 - (c) be followed by a meaningful examination.

D. Training

1. Training is currently available from:
 - (a) Canadian Faculties of Dentistry undergraduate and graduate programs.
 - (b) Canadian Faculties of Dentistry continuing education programs.

E. Professional Responsibilities

Dentists administering nitrous oxide and oxygen must:

1. Have taken sufficient recognized instruction to;
 - (a) conduct a proper evaluation of patient medical status as a determinant of ability to tolerate the drug administration. (A recorded evaluation is mandatory);

E. Professional Responsibilities (cont'd.)

- (b) understand the pharmacology (including contraindications, dosage, adverse response, and be prepared to deal with adverse reactions);
 - (c) be familiar with the equipment;
- 2. Accept the responsibility of ensuring proper installation, subsequent functioning, regular disinfection and periodic monitoring of the equipment system.
- 3. Adhere to the policy that nitrous oxide and oxygen must be administered only by a licensed dentist who should be in the room at all times during its administration. An auxiliary must be present to assist in the treatment room during the administration of nitrous oxide sedation. In the case of female patients, the auxiliary should be female.
- 4. Ensure that the drug is administered only to those patients who have a legitimate indication for its use and who understand its purpose, its effects, and who consent to its use.
- 5. Ensure that a patient receives an adequate recovery period in a supervised recovery area following the administration before being allowed to leave the office. When the dentist's judgement indicates, patients should be cautioned against operating machines or driving vehicles immediately after the appointment.

F. Equipment

- 1. Equipment for nitrous oxide and oxygen conscious sedation must:
 - (a) deliver a minimum of 30 % oxygen;
 - (b) not function unless this minimum flow of 30 % oxygen is present in the system;
 - (c) be equipped with connectors which will allow adaptation of a full face mask for possible resuscitative procedures.
 - (d) be equipped with an acceptable scavenging system

G. Safety Recommendations

As noted, scavenging devices must be employed for the safety of dental personnel. Nitrous oxide levels in the dental operatory should also be periodically monitored by an appropriate means (such as lapel monitors).

Health Care

Revised May 30, 1986

* Drawn from Guidelines prepared by The Royal College of Dental Surgeons of Ontario

DRAFT

**POLICY STATEMENT *
ON
SWEETENERS IN MEDICATION**

The Canadian Dental Association is concerned about the high levels of sugar used as sweeteners in both prescription and over the counter drugs. The sugar content of the formulations is from 20 per cent to 60 per cent on average.

Patients particularly at risk include small children and infants on long-term medications who have not yet established proper oral hygiene. Disorders that may be treated could be asthma, recurrent otitis media or cardiac defects. The presence in the mouth of sweet syrupy medications could cause the same high rate of dental caries as baby bottle caries.

Research has shown that there are sugar substitutes that cause little or no dental caries.

The Canadian Dental Association position is as follows:

1. Health Care practitioners, especially paediatricians, dentists and pharmacists, should be made aware of the high sugar content of medications and try to prescribe drugs employing non-cariogenic media suitable drugs. Also, that they should advise patients or parents of small children of the risk of more tooth decay from chronic use of a sugar sweetened drug. Parents should also be informed on how to develop a proper oral hygiene program, for their children.
2. The Pharmaceutical Manufacturers Association and Proprietary Drug Association should be made aware of the high risk of decay associated with prescription and over the counter drugs containing sugar and should be encouraged to employ sugar substitutes in medications.
3. Health and Welfare Canada should be encouraged to have medications marked as to sugar content and to promote the use of alternatives to sugar in medications.

The Canadian Dental Association is always interested in the best dental health care of Canada's population and prevention of decay by the removal of sugar from medications is one more step towards ideal oral health for all.

* Drawn from ODA Policy Statement prepared by the Health Care Committee November 1985.

Health Care, Jan. 1986

DRAFT CDA POSITION ON THE USE OF TOBACCO PRODUCTS

The Council on Health Care recommends:

1. that dental patients be made aware that the use of tobacco products (smoking, using smokeless tobacco and chewing tobacco) affects general and oral health and hygiene and should be discouraged;
2. that resource materials be developed to assist the dental profession in implementing policies restricting smoking in dental practices and illustrating the potential impact of the use of tobacco and smokeless tobacco products on oral health;
3. that smoking be banned at all official meetings of the Canadian Dental Association;
4. that smoking be banned in meeting rooms at conferences sponsored by the Canadian Dental Association.

BJH:dh

July 1986

CDA and DENTAL IDENTIFICATION SYSTEMS

A DISCUSSION PAPER

BACKGROUND:

At the November meeting of the CDA Council on Health Care, Council approved a resolution in support of systematic denture marking for identification purposes. The wider question of whether the Canadian Dental Association should take a position on using human teeth as the location for identification discs was referred to the Executive Sub-Committee of Health Council. It was recognized that some public demand for dental identification systems exists, that a Canadian system, developed by Dr. Phil Samis, is gaining international acceptance and that the public interest can be served by some such permanent identification system because of factors including the large number of children abducted annually and the need to identify accident victims, etc. Council expressed some initial concerns about using invasive procedures on healthy teeth, even with patient consent. It was noted that Dr. Samis' system offered non-invasive alternatives as a matter of choice.

EXECUTIVE SUB-COMMITTEE ACTION:

The Executive Sub-Committee has decided that the question of Dental Identification Systems and CDA initiatives deserves further consideration by Council. It appears that dental identification systems will develop, in response to perceived need, with or without national recognition and co-ordination. The American Dental Association has become involved at the national level in the United States (See attached). The Canadian Dental Association may be able to play a similar national role and has the advantage of the existence of a Canadian dental identification system, developed by Dr. Samis, which is currently available and already well-established. The Executive Sub-Committee of Council accordingly asks Council to consider the following questions, in the order listed.

Questions for Discussion

1. Should the Canadian Dental Association take a position on the use of dental identification systems (or on the conditions under which dental identification systems are regarded as acceptable).

ELABORATION: Should CDA support or not support the use of such systems? Are there conditions with respect to types of system, impact on the healthy tooth or other qualifying concerns that CDA should state for public guidance.

2. If so, should CDA take a position on the kind of identification system (marking system) to be employed on the identification disks? What method of marking is recommended?
3. Should CDA publicly identify those systems it regards as professionally acceptable (i.e. meeting any identified conditions or qualifying concerns).

ELABORATION: CDA already grants public recognition to tooth pastes with fluoride. Should it provide public recognition for ID systems with potential impact on the teeth?

4. Should CDA become involved in any operation or facet of a national dental identification process, such as:
 - maintenance of a national registry and phone line
 - promotion, distribution or sale of approved systems/supplies?

BJH:dh

Health Care
Jan. 16, 1986

APPENDIX VII

HEALTH SCREENING PROJECT SUMMARY OF RESULTS OF PHYSICAL AND LABORATORY EXAMINATIONS PERFORMED DURING THE CONVENTION MEETING OF THE CANADIAN DENTAL ASSOCIATION

September 30 - October 1-2, 1985.

During the 3 day period physical and laboratory examinations were performed on 175 dentists. Before the examination each dentist was asked to complete a two page questionnaire covering past medical history, current medical problems, vaccination history and current life style. During the 15 minute physical examination an assessment was made of general fitness and of major systems such as cardio-vascular, central nervous, pulmonary, musculo-skeletal and gastro-intestinal. Rectal examinations were not performed.

Extensive laboratory procedures were conducted to detect a wide variety of acute and chronic diseases. Serologic tests were done to detect exposure to some of the infectious agents which spread through the close-contact environment which may occur in the dental operatorium. Samples of nail and hair were collected as part of a separate study to determine exposure to mercury.

Of the 175 participants 169 were males and six were females. Ages ranged 25 to 80 with an average of 44.7 years. Results of the physical examination are available on 174. Laboratory findings are available on 175 except that in one instance, a tube of serum submitted for hepatitis studies, was lost.

SUMMARY OF PHYSICAL FINDINGS

This summary is derived from a review of each participant's history and physical examination and includes both current and past medical problems.

Eleven (6.3%) were considered to be significantly overweight while another 10 (5.8%) were somewhat overweight. Twenty (11.5%) had some degree of hypertension and an additional 9 (5.2%) had hypertensive blood vessel changes in their eyes. Eight (4.6%) had a history of low back problems and 11 (6.3%) had had serious hip-joint or knee joint problems. Two had had surgery for a pilonidol cyst. Three had cataracts and one was a known diabetic. One patient had had a coronary by-pass procedure and one had had, recently, a herpecteo whitlow.

LABORATORY STUDIES

It was not possible to collect fasting samples of blood for biochemical studies. In consequence elevated blood glucose and blood triglyceride levels may have little significance. Twelve participants were found to have elevated blood glucose levels which were not considered to be significant. One had a more highly elevated level along with the presence of glucose in urine. Fifty-one participants had elevated blood triglyceride levels, although in some instances, the elevations may have been a reflection of an increased food and alcohol intake during the convention. In several instances the elevated levels correlated well with the participants drinking habit and/or with his or her weight. Three patients who had elevated triglyceride levels also had elevated blood cholesterol levels.

Nine participants had increased blood levels of creatine kinase isoenzymes. Although increased isoenzymes are seen in a variety of conditions including myocardial infunction, they are also seen in joggers and other fitness buffs. Twelve participants had moderately elevated alanine aminotranferase enzyme blood levels. These enzymes are produced by the liver and the elevated blood levels may reflect a previous viral infection such as hepatitis or infectious mononucleosis. Three participants had elevated bilirubin blood levels, suggesting some liver impairment. Five had elevated blood ureal levels suggesting some impaired kidney function.

SEROLOGIC STUDIES

HTLV-III/LAV (AIDS) Virus

Extensive serologic testing at the Laboratory Centre for Disease Control failed to detect antibody to this virus in any of the participants.

Hepatitis B Antigen and Antibody

Serologic studies performed at the Regional Public Health Laboratory revealed that one participant was antigen positive. One hundred and three were antibody negative including twelve who had received Hepatitis B vaccine. While several of those had not yet completed the vaccination program or had completed it only recently, others had completed the program for as long as two years and, clearly, were vaccination failures. Most vaccination failures have been attributed to injection of the vaccine into the gluteus muscle rather than into the deltoid muscle.

Sixty-nine participants were antibody positive. Of these, forty-six were known to have been vaccinated while the remaining twenty-three are presumed to have had a past infection. A native Hepatitis B antibody rate of 13.2 per cent would seem to compare favourably with that found in other health care workers who are at risk for this infection. It should be noted, however, that the evidence of Hepatitis B antibody in non-immigrant Canadians is in the order of 0.5 per cent.

EPSTEIN-BARR VIRUS

Epstein-Barr (E.B.) virus causes infectious mononucleosis in temperate climates, pharyngeal carcinoma in Chinese and Alaskan Inuit and Burkitt's lymphoma in children in parts of Africa. It is thought to spread by droplets requiring close contact. Infectious mononucleosis is sometimes referred to as kissing disease.

Clinically evident infectious mononucleosis is rare in pre-pubescent children, although many are infected. It is not uncommon in teenagers and young adults. It now is occurring more frequently in older adults.

Serologic tests for antibody to the viral capsid, the E.B. virus, were conducted at the National Reference Laboratory at St. Justin's Hospital in Montreal. Eight (4.6%) of 175 dentists had no serologic evidence of infection by this virus. Sixty-seven (38.3%) had low levels of antibody to the E-B virus while 100 (57.1%) had relatively high levels. Comparable data from other occupation groups of similar composition are not readily available. In the opinion of Dr. Joncas the Director of the National Reference Laboratory, the high rate of positive responses is not particularly unusual.

REdh

June 5, 1986.

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

REPORT TO THE ANNUAL MEETING CDA BOARD OF GOVERNORS AUGUST 1986

Members: Dr. J.H. Gryfe, Chairman, Ontario
Dr. C. Foster, Manitoba
Dr. J. Hardie, Ontario
Dr. V. Legault, Quebec
Dr. E.L. MacInnis, Nova Scotia
Dr. W.S. Walter, British Columbia

Executive Liaison

Dr. J. W. Niedermayer, Saskatchewan

Staff: Mr. B. J. Henderson, Director of Accreditation
Mrs. L. Emmerson, Secretary to Council

1. Council Meetings

The Council has met once since the last report to the CDA Board of Governors, on June 20 & 21, 1986 in Ottawa.

2. All members were in attendance at this meeting. Also present for the entire proceedings were the Director of Accreditation and the Executive Liaison, Dr. Jack Niedermayer. Dr. J. Bernard Poindexter Jr., Chairman of the ADA Council on Hospital and Institutional Dental Services was an invited guest for this meeting.

Items for Information Not Requiring Board Action

3. Base line data for government insurance coverage in each of the provinces has been amassed. The results of this questionnaire will be available for the interim meeting of the Board in 1987.
4. A resource document outlining Procedures for Oral Care of Chronic Care Patients has been approved by this Council in principle and has been returned to Committee for final adjustments. It is expected to be presented as a document for Board consideration at the interim meeting in 1987.
5. We were honoured with the presence of Dr. J. Bernard Poindexter Jr., the Chairman of the American Dental Association Council on Hospital and Institutional Dental Services during our meeting. Dr. Poindexter outlined some of the problems being encountered with both open panel and closed panel health delivery systems in the United States. His addition to the meeting was a great benefit and all attempts should be made to continue this active liaison between the Committees of ADA and the CDA.

COUNCIL ON HOSPITAL & INSTITUTIONAL SERVICES

Page 2

6. A report was presented on the Prelicensure Conference and it was the feeling of this Council that the Council on Hospital & Institutional Services continue its efforts to expand dental service accreditation to a wider variety of dental departments of institutional facilities and further Council believes that the concept of Prelicensure has been adequately expanded by the Joint Conference and that further developments should be taken by the Canadian Faculties of Dentistry.
7. The Council Chairman reported on his attendance at the ADA Council on Hospital and Institutional Services and highlighted their work in progress. A proposal regarding the development of protocols for treatment of special medical patients requiring both medical and dental care is presently under discussion by the ADA and our Council feels that this should become an item of priority for the CDA as well.
8. The results of the Ontario Hospital Association survey of dental services in hospitals was reviewed and this Council will initiate discussions with the Canadian Hospital Association in an attempt to expand this service into a nation-wide service.

Surveys

9. The following hospitals have had their Dental Service accredited:

Montreal General Hospital
Jewish General Hospital
Royal Victoria Hospital
Winnipeg Health Sciences
Winnipeg Children's Hospital
Deer Lodge Hospital
Vancouver General Hospital

The Council on Hospital and Institutional Services is happy to note the ongoing co-operation with the Council on Education and Accreditation has made their combined participation in future surveys an assured fact.

10. The Chairman wishes to thank the Director of Accreditation and the Co-ordinator of Accreditation for their immeasurable assistance in the smooth functioning of this Council.

Respectfully submitted,

J. H. Gryfe, D.D.S. Chairman
Council on Hospital &
Institutional Services

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Hospital & Institutional Services with appreciation.

COUNCIL ON INFORMATION SERVICES

1.

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Council Members: Dr. Y. Kamachi, Chairman, Ontario
 Dr. R. Howaniec, B.C.
 Dr. W.T. Koltek, Manitoba
 Dr. G. Lafrenière, Québec
 Dr. C.S. Leblanc, N.B.

Executive Liaison: Dr. E.F. Allison, Calgary, Alberta

1. Council Meetings:

Council has met once since the last Board, on June 6, 1986. Mr. Mark Sarnier was a guest at this meeting.

Items Requiring Board Action

2. Dental Awareness Program

APPENDIX I

At the April 1986 Interim Board, Council recommended and the Board approved retention of Manifest Communications Inc. as consultants for the Dental Awareness Program, years three and four (provided budget expectations were met) and requested that Manifest present a series of different program proposals and budgets for continuation of the DAP. In keeping with this directive, Council reviewed the attached proposal for phase two of the CDA's Dental Awareness Program, 1987-88.

Council feels that the proposal is sensitive to the overall budget picture for CDA in the ensuing two years, while still being both appropriate and realistic to the mandate of the program as a whole. The initial objectives of the program have been retained. The program plan has become more refined and better focused. Dentists remain a central focus of the program and will be encouraged to undertake a greater role in it. Adult Canadians remain the primary public target audience. Dental health month has been integrated into DAP activities, representing a \$75,000 expenditure in all three proposals. The provincial associations will continue to play an important role. It is anticipated leverage will increase by up to 50% over levels established in years one and two. Liaison activities with the provinces far exceeded our expectations during the past two years, and phase two programming reflects this reality. A fall visitation to each provincial dental association has been incorporated into future programming activities. Council feels this is an important aspect of the program and should be retained in each year of the program, if possible.

COUNCIL ON INFORMATION SERVICES

It is noted that phase two programming reflects some major changes in the DAP. Public service advertising will take on a greater and more dynamic role. In addition, greater emphasis will be placed on member resources and public education.

Reduced dollars will be spent in the areas of media relations, corporate sponsorship and joint initiatives with the expectation that our building block approach over the past two years will yield concrete results without the same level of effort by the program. The program also will attempt to move in-house a greater number of administrative tasks, such as media monitoring, to reduce consulting costs.

Greater emphasis will be placed on joint initiatives with Health and Welfare, and other health-oriented groups. Research studies are also planned to measure the program's impact in the public and professional arena.

Council unanimously feels that the Manifest proposal for years three and four accurately reflects the future direction for CDA's Dental Awareness Program. In keeping, however, with CDA's current financial position, Council unanimously and strongly recommends:

RESOLVED:

86.96 **THAT for the year 1987 a basic budget of \$225,000 be accepted for continuation of the Dental Awareness Program.**

ADOPTED**RESOLVED:**

86.97 **THAT for the year 1988, a projected budget of \$250,000 be recommended for the Dental Awareness Program.**

ADOPTED

Council notes that no monies have been allotted for continuation of the DAP from October 1, 1986 to December 31, 1986. Council thus recommends:

RESOLVED:

- 86.98 THAT an interim budget, not to exceed \$45,000 be approved for the period October 1, 1986 to December 31, 1986 in order to maintain the Dental Awareness Program until the 1987 fiscal year.

ADOPTED

Council feels that the monies it is recommending for continuation of the DAP are basic to the program's development, and will both demonstrate and emphasize to government, corporations and the public, CDA's commitment to dental health programming. This commitment is essential to any future support the program may receive from outside groups and agencies.

Items Not Requiring Board Action3. Dental Health Month 1986

Council is pleased to note the success of its 1986 Dental Health Month programming efforts. The "Dental Health: Good for Life" theme was adopted by most provinces and a number of major dental corporations for their 1986 DHM activities. All DHM materials carried the Good for Life theme and were designed to be used year round for dental health promotion. Numerous orders for materials were received from provincial associations, individual dentists, health clinics, hospitals, schools and Health and Welfare, and total as follows:

Planning Kits	-	1,200
Posters	-	16,005
Decals	-	147,500
Buttons	-	38,500
Cassettes	-	58
Supplements	-	99,582

Revenues accrued to DHM, May 30, 1986, total \$27,624 with additional outstanding funds expected shortly.

1986 DHM programming highlights include:

COUNCIL ON INFORMATION SERVICES

-
- publication of the second National Dental Health Checkup in Chatelaine magazine with a distribution of over 1.1 million English and 300,000 French copies that will reach over 6 million Canadians. Chatelaine is conducting a readership survey in its May issue and preliminary results reveal a positive public response to the supplement and a desire to pull out and save the insert;
 - a direct mailing (via CDA's Communique) to all CDA members, of DHM materials (poster, button, decal), four fact sheets, the second National Dental Health Checkup, and the second DAP Report on "Communicating Care" to patients;
 - distribution of over 1,200 planning kits and media kits to provincial bodies for internal dissemination;
 - successful participation by seven of the ten provinces in CDA's poster contest. Ontario representatives won in all three age categories and winners will receive a congratulatory letter and a \$175 cheque;

APPENDIX II

- media coverage increased dramatically from that of previous years. In 1984 only 100 print exposures were monitored. In 1985 this increased by 300%. In April 1986, this figure again increased by 300%. Monitoring of the electronic media also reveals dramatic increases from that of previous years;
- a very successful Ottawa reception was held on April 2 to launch DHM 1986. Close to 100 key representatives from Health and Welfare and other government departments, health care associations and major dental corporations attended to learn more about CDA's Dental Awareness Program and to launch dental health month. CDA received positive feedback and laudatory remarks from attendees and was better able to position itself as a health care leader in Canada.

4. Dental Health Month 1987

Pending budget approval, plans for DHM 1987 are being formulated. The "Dental Health: Good for Life" message will be retained to be supplemented by the theme "Make the Good for Life Commitment". Planning kits will be retained and additions made to 1986 materials. A new poster will be developed and provincial visitations are being planned this fall to announce programming activities.

5. Media Relations

As indicated under 1986 DHM activities, media exposure has increased dramatically during the last four months on a number of different operating levels - print, radio and television.

Since the launch of the DAP in 1984, print media coverage has increased by over 300%. Between April 1985 and January 1986, 766 print articles were identified. Statistics for the period February 1986 to mid-May 1986 reveal 1583 items. Radio and television broadcasts in Toronto for the same periods are as follows:

<u>April 1985 - January 1986</u>		<u>February 1986 - mid - May 1986</u>	
8 months		4 months	
Radio	32	Radio	41
T.V.	10	T.V.	28

Ongoing contact has been nurtured with key media personnel. Media packages are sent out when appropriate, containing specific information on select items. In addition, CDA is being contacted on a much more frequent basis by scientific writers on the development of dental related articles for major newspapers and magazines.

6. Public Service Print Advertising Campaign

During April 1986, CDA launched a public service print ad campaign to be used on an ongoing basis. Media monitoring reveals that over 66 filler ads were published in daily and weekly newspapers during Dental Health Month.

It is anticipated that public service advertising in all media forums will play a much greater role in phase two of the program.

7. Provincial Relations

Corporate bodies are kept informed of DAP/DHM activities on an ongoing basis. Regular memos are sent to Chief Executive Officers and DHM Chairmen as programs develop. In addition, both planning workshops and media training sessions have been held on site to meet provincial programming needs.

It is anticipated that planning sessions will again be held in the fall to assist corporate bodies in their programming efforts and to coordinate CDA-provincial DHM activities. DAP activities in 1987 will continue to stress the importance of provincial relations, and greater time and effort will be given to ensuring that corporate members are communicated with and consulted on an ongoing basis.

8. Member Relations

The continuation and expansion of communication to the members remains an integral part of the DAP. The quarterly CDA Communique contains, on an ongoing basis, a section devoted to DAP information. Each CDA member receives the DAP report in conjunction with the Communique. The March DAP Report on "Communicating Care" to patients appears to have been very well received by members.

In addition, the CDA Journal carries a regular DAP column in each issue. Each CDA member has received four easily reproducible fact sheets and more sheets are being planned for future mailings. Additional copies of both the 1985 and 1986 Checkup are also available to members on a request basis.

A seminar will be presented at the August 1986 CDA Convention on "Dental Awareness: How It Can Work For You". If successful, seminars will be conducted across the country on a cost recovery basis.

9. Targeted Programming

A number of targeted program efforts have been developed and continue to be initiated under the auspices of corporate sponsorship. Key programs include:

- Colgate-Palmolive's sole sponsorship of the second National Dental Health Checkup in Chatelaine at a cost of close to \$300,000;
- Oral B's exclusive sponsorship of an adult oriented CDA pamphlet entitled "What Every Adult Should Know About Dental Health". Oral B will absorb a cost of approximately \$250,000 within the first year of a three-year commitment. Over 1.2 million pamphlets will be produced for distribution to pharmacies, in dental health kits and through direct mail. CDA will obtain 250,000 copies to include in its pamphlet program and to forward directly to the dental office. It is anticipated that this pamphlet will be ready for distribution shortly.

COUNCIL ON INFORMATION SERVICES

- A targeted seniors' program for City of Toronto residents that amalgamates the efforts of CDA, the Ontario Dental Association and the City of Toronto to make senior citizens more aware of the importance of good dental health. The City of Toronto is paying CDA \$20,000 to support DAP involvement in this project. Literature is being developed and will be promoted to seniors throughout Toronto. This program is being viewed as a pilot project by other major Canadian cities;
- a recall program is being developed to aid the dental team in bringing patients into their office for regular checkups. Both instructional and resource materials will be available, hopefully funded by sponsorship dollars.

10. Leverage

To date, CDA has obtained approximately \$1 million in leverage from corporations and outside agencies supporting the "Good for Life" initiative.

11. Research

As mentioned in the last Board report, two major initiatives were undertaken in 1985 - a survey of health educators (to measure the need for and type of materials required by the public) and the Gallup National Omnibus Poll (to measure public perceptions of dental health). The results of this latter study were communicated to the profession in the first DAP Report last December.

A readership survey, currently being conducted by Chatelaine magazine in its May 1986 issue, will yield results on the public's perception and reaction to the second National Dental Health Checkup. Results will be forthcoming shortly.

In addition, major discussions are underway with Health and Welfare Canada to obtain a research grant to measure the impact of the DAP on public attitudes. If successful, CDA could receive funding by July 1987 to initiate a three-year research project in this area. Council recommends that CDA seriously pursue federal government research funding for this endeavour.

COUNCIL ON INFORMATION SERVICES

12. Review of CDA's Pamphlet Program

Over the next six months, Council will undertake an extensive review of CDA's pamphlet program. CDA continually receives requests from both the public and the profession to expand its pamphlet selection and provide them on a more economical basis. Council has requested that Manifest review the current pamphlet program and recommend its future direction. It is anticipated that this will occur at Council's fall meeting.

13. Council Liaison with the Membership Committee

Council feels that there should be greater liaison between this Council and CDA's Membership Committee. We feel that DAP activities are valuable to members and they should be promoted and marketed as such. Council hopes that a greater liaison and communication can be initiated between both committees in order to better coordinate and promote DAP activities as a membership benefit.

14. Council Membership

Council has accepted with regret the resignation of Dr. Clement LeBlanc from New Brunswick. Dr. LeBlanc has recently been appointed to the CDA Board of Governors and has resigned from Council in order to avoid a potential conflict of interest.

Council extends its sincere appreciation to Dr. LeBlanc for his hard work and efforts on our behalf over the past five years.

Respectfully submitted,

Y. Kamachi, D.D.S.
Chairman,
Council on Information Services

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Information Services with appreciation.

DENTAL HEALTH



THE DENTAL AWARENESS PROGRAM: 1987-88

Proposed Plan For Phase Two

prepared for

Executive Council
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario

by

Manifest Communications Inc

6 June 1986

"Dental Health Good for
Life" is a public
information and
awareness program of the
Canadian Dental
Association

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EXECUTIVE SUMMARY

This paper presents a proposal to enable the CDA to sustain an effective and cost-efficient Dental Awareness Program through 1988.

Two Objectives:

The Program's overall objectives remain to:

- o Increase patient traffic in dentists' offices
- o Promote improved dental health among Canadians

Two Criteria:

- o Executable within controllable CDA resources
- o Appropriate to a professional association

The Dental Awareness Program Today

- o DAP has met short-term objectives:
 - . Visibility is up dramatically
 - . Members are getting information and resources
 - . Targeted programming has been executed through sponsorship
- o DAP has had a demonstrable impact on several key audiences:
 - . Health & Welfare Canada: lauds CDA for leadership and innovation in health promotion; wants to work with CDA
 - . Media: coverage is up an estimated 300% -- 1,000% during April
 - . CDA members: DAP information and resources are proving useful and are appreciated
 - . Provincial Associations: actively supportive; adopting DAP theme; accessing resources; inspired to act
 - . Corporations: sponsorship is at \$1,000,000; target should be reached in 86; strong interest in further involvement.

- o The public still must be moved:
 - . Gallup Poll indicates complexity of doing so
 - . next phase calls for increased targeting of issues and audiences
 - . greater reach and frequency of message delivery
 - . lean budget

CDA's Message: "Dental Health: Good For Life" The theme provides a conceptual framework for reorienting the public to dental health and dentists:

- o Dental health: An ongoing, personally productive form of preventive health practice. A package of daily behaviours: brushing, flossing, eating properly. Regular visits to the dentist.
- o Dentist: A trained health specialist with an essential role to play in a personal dental health program.

Target Audiences

- o Primary: CDA member dentists (& staff), the general public - predominantly adults (18+)
- o Intermediary: Corporations, selected health organizations - federal and professional, media

Strategy: Sustain and expand the "Good For Life" program targeting predominantly adults and CDA members through:

1. **An expanded and intensified public education campaign**: highly visible information programming, more focused media relations, dramatically expanded public service advertising, further integration of Dental Health Month;
2. **More direct involvement of the profession in patient education and motivation programming**: targeted programs to educate and motivate sectors of the public to preventive dental health and the importance of seeing a dentist as a first step;
3. **Increased CDA leadership in the dental health promotion efforts of relevant societal sectors**: better working relationships with provincial associations, sustained involvement of corporate sponsors, joint initiatives with selected federal government and professional groups;

4. **Market Research:** studies to guide programming and to monitor impact among the public and the profession.

BUDGETS

Three Plans

Council On Information Services has recommended a net CDA budget of \$225,000 for 1987 and \$250,000 for 1988.

Two further options are included as presented to CIS: \$275,000/year and \$300,000/year. The utilization of the extra funds is specified along with the benefits accruing to the Program.

All three plans include \$75,000 budgeted for Dental Health Month.

Leverage

The value of corporate and other support is estimated for each plan. For the CIS recommended plan, leverage is projected at an estimated \$982,000 in 1987 and \$1,067,000 in 1988.

Interim Budget

Budgets are for the period January 1, 1987 through December 31, 1988.

To maintain the continuity of the Program through the interim period between the end of the first two-year plan and budget and the beginning of the 87 plan (October 1 - December 31, 1986) CIS has recommended funding in 1986 not to exceed \$45,000.

ONGOING COMMITMENT

In the first two years of the Program, CDA has established what has been called a leading health promotion program in Canada. The next two years will expand on that success and should yield real and measureable benefits: improving awareness among Canadians of their dental health and increasing appreciation and utilization of the dental profession as a means of helping keep their dental health good for life.

INTRODUCTION

At the request of CDA, Manifest has prepared the following plan for the Dental Awareness Program in 1987 and 1988, years three and four of the Program.

This paper has been prepared for consideration by CDA Executive Council. It incorporates those changes specified by the Council On Information Services (CIS) on June 6, 1986. It includes both the budgets recommended by CIS and the options presented for their consideration. Also included is a budget proposal for the period between the end of the current two-year plan and the beginning of the 1987-88 program.

The 87-88 plan is designed to build on the foundations laid in the first two years for an ongoing CDA dental health promotion program. Equally important, it allows the CDA to do so within a sound financial framework.

The proposed plan enables CDA to:

- o expand the public awareness campaign to communicate the importance of dental health and the central role of the dentist in preserving and protecting it;
- o sustain effective working relationships with provincial dental associations in awareness-type programming;
- o increase the access for CDA members (and their staff) to information and resources that can help them expand and improve the delivery of dental health services;
- o increase the leverage of CDA funds by up to 50% over the level established in the first two years of the Program.

Restructuring and Refinement

The plan calls for a degree of restructuring within the existing Program:

Dental Health Month, while retaining a separate budget and its unique role as a joint promotion of CDA and Provincial Associations, now formally becomes a component of the Program.

Provincial Association Liaison now becomes a component of the Program in its own right, as the means to sustaining the effective working relationship that has developed between DAP and provincial counterparts.

Public service advertising, introduced in 1986, takes on a more dynamic role in the public campaign as a means of expanding the presence of CDA's message.

Plans for both the Public Education and the Member Resources components call for higher levels of activity. Throughout, there will be greater emphasis on research as both a planning and a monitoring tool.

The Media/Public Relations component will be able to maintain its effectiveness by exploiting contacts developed over the first two years and by concentrating activities to a greater extent.

Corporate Sponsorship will generate a far higher level of leverage.

Joint Initiatives will be confined to working with the federal government and with key groups such as hygienists, assistants and the public health system.

Cost Consciousness

In short, the 87-88 plan calls for a definite expansion in the level of DAP activity. It will do so within tight financial parameters. The plan recommended by CIS involves a reduction in CDA funding to \$225,000 in 87 and \$250,000 in 1988.

The two options presented enable CDA to measure the value of maintaining the Program at its original dollar level -- and of maintaining its original purchasing power by adjusting upward for inflation. In all three plans, Dental Health Month has been retained at its traditional \$75,000 level.

Whatever the funding decision, leverage will continue to finance the bulk of DAP activity in the coming years. In fact, the projected expansion of the Program will be the result of a dramatic increase in the level of leverage activity. In the first phase, the plan projected leverage of 4:1 over two years. The 87-88 plan is designed to achieve virtually the same level on an annual basis -- to generate approximately \$1,000,000 per year in funding and resources to compliment CDA's budget.

The ongoing success of the program depends on sustaining a number of carefully orchestrated communication and marketing activities. Each one is an essential component of the overall strategy. Results in the first two years have placed CDA in a position to increase its effectiveness in the next two, and to demonstrate that effectiveness in terms of growing public awareness and in terms of the ability of CDA members to better promote the fiscal health of their practices.

PROGRAM OBJECTIVES

The Program remains committed to its original long-term objectives:

- o Increase the average number of patient visits per dentist in Canada.
- o Promote improved dental health practices among all Canadians.

PROGRAM CRITERIAo Executable with CDA-controllable resources

The core of the CDA strategy must depend on resources that the CDA either controls or can directly bring into play. Specifically, the program should not hinge on the commitment and involvement of provincial dental associations; nor should it depend on special levies on members.

o Appropriate to a professional association

Much as the CDA wants to promote increased consumption of dentists' services, it cannot adopt the pure marketing orientation of a commercial enterprise. The CDA strategy must not compromise the dignity and professional image of itself or its membership.

THE DENTAL AWARENESS PROGRAM TODAY:"Alive And Well and Working In Canada"

At this writing, 19 months after its inception and 13 months since its public launch, the Dental Awareness Program is a CDA success story. From a standing start, CDA has been able to implement and sustain an innovative program that has achieved the objectives set for it in Phase 1. Visibility of the dental health issue and of CDA's commitment to it have increased dramatically. CDA members have increased access to information and resources to help them improve their patient communication efforts. And CDA has executed a variety of high-profile awareness and information activities across the country. The value of all this can be gauged in terms of DAP's impact on a number of key audiences:

- o Health and Welfare Canada cites DAP as proof that CDA is in the forefront of health promotion among private organizations in Canada and has encouraged CDA to pursue more productive working relationships with the department.
- o Media is now treating dental health as a far more central societal issue. Media coverage is up at least 300% over 1984. Dental Health Month 1986 coverage shows a 1,000% increase over 1984, the last pre-DAP April program. Feature print coverage and electronic media exposure are showing marked increases every quarter.
- o CDA member dentists are increasingly aware of the Program as a service of CDA and are enthusiastic beneficiaries of DAP resources. Anecdotal and written comments are positive.
- o Provincial Associations, initially skeptical, have virtually all become active supporters and increasingly dynamic players in the Program. Dental Health Month has been revitalized and DAP has inspired several provincial associations to plan for the expansion of their awareness-type activity under the CDA's "Good For Life" theme.
- o Corporations have demonstrated a willingness to support CDA's objectives and activities through approximately \$1,000,000 of sponsorship to date. Interest is strong for expanded sponsorship activity.

The Public Must Be Moved

The overall objectives for the Program remain the same: to promote increased awareness and motivate action we can see in the form of increased traffic in dental offices. While the Program has worked to open up key dental health issues -- most specifically adult concerns -- the public has yet to be moved in a demonstrable way. This sobering fact indicates both how much it takes to get the message across and how important it is to direct the momentum of the Program towards the long-term objectives with continuing commitment.

The 85 Gallup Poll indicates the nature and complexity of adult dental health attitudes and knowledge. There are significant barriers to be overcome. The aggressive plan for the next phase of the DAP campaign is designed to capitalize on the gains made to date by expanding and intensifying activity on all fronts. The plan calls for increased targeting of issues and of movable market segments and for greater integration of promotional and information efforts to achieve broader reach and more frequency. All these improvements are reflected in a more rationalized structure for programming activity and an emphasis on greater output from a "lean" budget.

CDA's Message For Canadians:**"DENTAL HEALTH: GOOD FOR LIFE"**

The "Good For Life" theme is the cornerstone of the DAP message strategy. It will continue to identify and unify all Program materials and activities as part of the ongoing effort to reposition both dental health and dentistry.

"Good For Life" provides a consistent and mutually reinforcing orientation for any and all messages. Through it, the public can readily understand and appreciate dental health, and see dentists as providers of a vital and productive service.

Positioning Dental Health

"Good For Life" provides the context for the continuing effort to reposition dental health in the public mind as:

- o A contemporary health issue -- one directly associated with the growing societal trend toward preventive health care.
- o An achievable goal -- appropriate personal action means the effective prevention, control and/or cure of dental health problems. This is a compelling idea.
- o An active pursuit -- the simple combination of brushing, flossing, nutrition, and regular consultations with a dentist.
- o A life-long pursuit -- broadening the definition of dental health to include adult problems such as periodontal disease specifically includes the adult public.

Equally important, it works to establish an ideal context within which to position and promote dentists and their services.

Positioning the Dentist

In Phase Two the dentists will receive increasing attention, positioned as: a **preventive health specialist, the sole provider of an essential service in a personal dental health program.**

Positioning the dentist as a preventive health practitioner creates the opportunity to correct current attitudes toward dentists and the services they provide:

- o **The image of the dentist will be enhanced:** The stature of the dentist is elevated considerably. He becomes less a technician, more a knowledgeable professional.
- o **The importance of seeing a dentist will be clarified:** As people become more aware of the pivotal role the dentist plays in personal dental health -- a role they do not appear to be aware of now -- the fact that such a service is available becomes more compelling.
- o **The nature of dental service will be transformed:** The emphasis on prevention focuses attention on counselling and diagnostic functions, de-emphasizing the drill and its negative associations.
- o **The benefits of regular consultations will be expanded:** The benefits of consulting the dentist can be shifted from simply the treatment of decay to the successful prevention of, or arresting of, dental health problems. Positive reinforcement for visiting the dentist can be used to benefit both the dental health of the patient and the economic health of the dentist.

This positioning of the dentist will help promote an improved understanding and appreciation of the profession. However, it will place increasing emphasis on the dental team's commitment to living up to this image and so fulfilling rising public expectations.

TARGET AUDIENCES

Primary Target Audiences

CDA Member Dentists

CDA dentists remain a primary target group, to be addressed both as a direct audience and as intermediaries in the public promotion of better dental health practices.

As a direct audience, it is essential that members understand the potential benefits of the CDA effort to promote dental health and that they understand their role in this effort.

As intermediary, the dentist must be aware of the nature of his role in the overall program. This role involves becoming more proactive in all communication efforts with present and potential patients.

Priority Public Target: Adult Canadians

The primary public target group is adult Canadians (18+). Based on review of the Gallup Poll and other available research, the most receptive adult segment would appear to be those 25-50, of middle and upper income, with good education, a history of regular dental care and some form of dental benefit coverage.

These people demonstrate significant ignorance of their vulnerability to dental disease, of effective means of preventing it and of the continuing importance of regular dental visits.

This sizeable population segment can best be reached through a combination of public awareness programming and direct communication efforts by dentists.

o The non-user benefit holder

It is estimated that up to 4.5 million people now covered by dental benefits do not visit a dentist regularly, and so are not availing themselves of a vital health service that would cost them little or nothing. Primary focus here should be placed on those involved in employee plans. Holders of social benefits are more difficult to educate and motivate.

This group can best be reached through their employers and through public awareness activity. (To date, it has proven difficult to find an effective route into companies. The effort must be continued.)

Intermediary Target Audiences

Dental Health-Related Corporations, Organizations, Industries

This sector has already demonstrated a willingness to support DAP activity. It will remain a focus of the Program for the purpose of generating continued sponsorship for priority activities and projects.

Directly Relevant Professional, Public Service, and Government Organizations

In Phase Two the focus will be narrowed to three or four high-priority organizations who have demonstrated a willingness to support DAP initiatives -- Health & Welfare, CDHA, CDAA and public health departments.

The Media

The media represent the most extensive (and among the least expensive) system of message delivery to the Canadian public. Dental health, properly promoted and packaged, will continue to gain considerable profile in all media.

DAP STRATEGY: 1987-88

The proposed DAP strategy is:

To sustain and expand the national public awareness and information program for the delivery of "Dental Health: Good For Life" theme and messages targeted primarily to adult Canadians and specific priority segments within the adult population so as to:

1. Consolidate and intensify the public education campaign:
 - o augment magazine supplements with information programming in other highly visible media (TV and radio) and with a line of consumer-oriented publications marketed directly to the public;
 - o manage media and public relations with growing emphasis on adult dental health issues, the dental service as a source of help and on the promotion of DAP projects and events;
 - o aggressively support a public service advertising campaign to increase the reach and frequency of the DAP message;
 - o facilitate the effective integration of national, provincial and community activity during Dental Health Month to maximize its promotional impact on awareness.
2. Involve the profession more directly at the office level in the implementation of patient education and motivation programming:
 - o increase the flow of information on how and why to execute office programming and how it is working for others;
 - o provide access to an increasing array of useful resources for office use;
 - o develop and promote training programs for the dental team as part of continuing education and professional development.

3. **Expand CDA's national leadership role in dental health promotion by promoting increased integration under the DAP banner of relevant societal sectors:**
 - o sustain working relationships with provincial associations to promote and assist in the development of provincial awareness programming;
 - o sustain the solicitation of corporate support for DAP programming;
 - o concentrate joint initiative efforts on a highly select group of public and professional groups including Health & Welfare Canada.
4. **Gather and maintain national market research on both the public and CDA's members.**

The above represents a restructuring of DAP activities. This restructuring is intended to enable the Program to manage its ambitious agenda more effectively over the next two years.

THE 87-88 PROGRAM

The reorientation of the strategy generates a restructuring of DAP activity along three distinct programming lines:

Public Awareness And Information Campaign

- o Public Education
- o Media/Public Relations
- o Public Service Advertising Campaign
- o Dental Health Month

Professional Programming

- o Member Resources
- o Provincial Association Liaison

Support Services

- o Market Research
- o Corporate Sponsorship
- o Joint Initiatives

The following pages outline each of the nine components and their role within the program as a whole. Each component requires an ongoing program of marketing and/or communication projects and activities, the most important of which are identified and briefly described.

The list of projects and activities is by no means definitive. The nature and content of these activities may well change in the context of further strategy refinement and budgeting.

I PUBLIC EDUCATION

The **Public Education** component will continue to be the home of the Program's campaign management and administration.

It will also be the component devoted to the creation of information products for both broad and narrow public target groups. All projects are to be funded entirely through sponsorship and/or joint initiatives. Resources planned for 87-88 include:

1) National Magazine Supplements

A minimum of one supplement/year to appear in a national publication such as **Chatelaine** and **Maclean's**.

2) Dental Health Television Programs

Television programming for both network and syndication is currently in the early discussion stage. The plan is to make the **1987 National Dental Health Check-Up** a national television special. If successful, it will generate opportunities for other forms of television programming.

Programs will be designed to allow repackaging for educational markets and for the public health system.

3) Consumer Booklet Program

A special booklet series targeted to consumer issues to be created for direct distribution to the public. The series will become a central tool of information programming, promoted through media relations and other activities. In addition, it will be available to members for patient education purposes.

The series is part of the overhaul of CDA's current publication program.

Special Markets4) Dental Benefits Awareness Program

This program, conceived in Phase One, but still lacking sponsorship, remains a priority. Intended to increase awareness and utilization of dental benefits, this program would be delivered to benefit holders through the workplace. Elements of the program will be determined in consultation with employers to ensure ease of distribution. Likely elements are a booklet, poster(s) and articles for employee newsletters.

5. Children's Dental Health Program

While children's dental health is not a priority issue for DAP, it is valuable for CDA to maintain a visible commitment to children. Discussion is underway on two projects for 87 and 88, either of which would satisfactorily demonstrate CDA's continuing concern.

II MEDIA AND PUBLIC RELATIONS

The Media/Public Relations program will sustain high levels of exposure in both public and specialized media for dental health issues, ideas, and developments relevant to the CDA's objectives.

Building on effective working relationships with key media, the program will increasingly concentrate around specific issues such as periodontal disease and special DAP events such as the publication of supplements, the airing of a t.v. show and the release of the consumer booklet series.

Activities within this component will include:

1) Media/Public Relations Services

The identification of opportunities, preparation of materials and liaison with media outlets.

2) Media/Speech Training

CDA's President plays a pivotal role in the Program as official Association spokesperson. Each new President should receive training for media and for speech-making opportunities.

3) DAP Briefing Book Updates

In Phase One, a DAP Briefing Book was developed and produced to allow spokespeople, CDA management, staff and executives to answer questions and address issues relevant to dental health and dentistry in general. The Briefing Book is to be maintained and updated as and when necessary.

4) Media Information Kit

The core content of the kit -- information on the overall CDA program -- is already in hand. This material will be complemented periodically by event-, project-, or issue-specific information and materials as required.

5) Media Monitoring Program

To become a CDA staff responsibility in 1986 and to be treated as a CDA operating expense.

III PUBLIC SERVICE ADVERTISING CAMPAIGN

Advertising has a distinct and important role to play in building awareness, providing information, and motivating attitudinal and behavioural changes. In Phase Two, it moves to a more dynamic position within the public education campaign.

A public service ad campaign in print and radio was created in 1986. It has begun to generate free exposure in newspapers and periodicals. While there is significant resistance among media to giving free space to dentistry, this can be overcome in time through sustained effort by DAP, provincial and local dental groups to clarify the public side of the issue -- and by providing compelling creative that media would like to run.

In addition, corporations have indicated strong interest in supporting a CDA campaign through the purchase of ad space. A combination of space donated by media and that purchased through corporate support will generate campaign visibility at very low cost to CDA.

The campaign will certainly continue in print and, in an expanded form, on radio. Television will only be added if sponsors are willing to support it with an adequate level of media buying.

The Program will continue to make campaign materials available to provincial associations for use in their own awareness campaigns on a public service or a paid basis.

Elements of the campaign for which DAP will be financially responsible are:

1) Campaign Strategy and Creative Development

Current ad materials will have to be augmented periodically with fresh creative. The radio component will require further development and production. Television spots will have to be created, evaluated and, to a certain degree, financed.

2) Media and Corporate Liaison

Recruiting free public service space and time will require proactive personal and written promotion to key media: national magazines, major radio (and television) stations, primarily in Toronto and Montreal.

Working with sponsors will involve liaison with their agencies and media planning.

IV DENTAL HEALTH MONTH

Dental Health Month has been revitalized as a national promotional program. It will stay in April. And it will continue to be a co-operative endeavour between CDA and provincial dental associations.

The overall theme for Dental Health Month will remain that of the Dental Awareness Program itself: "Dental Health: Good For Life". CDA will continue to provide national focus around a special annual theme and national promotional support in the form of special media relations programming and the co-ordination of special national projects timed for April such as magazine supplements. CDA will continue the policy introduced in 1985 of providing each CDA member with a free DHM office promotion kit. CDA will continue, as well, to create and provide provincial associations with access to promotion and information resources: buttons, posters, decals, press materials and community programming guides.

The working relationship between CDA and the provincial Dental Health Month chairpeople will be further improved through a better planning timetable and through the continuation of regular communication with provincial associations.

DAP activities in this area will include:

1) DHM Planning, Creative Development, DHM Liaison

The development of the annual DHM plan, creative development of all communication materials and the maintenance of regular communication with provincial DHM chairpeople.

2) Production and Management of Materials

Production of materials, order processing, inventory management and shipping to the provinces are handled through the Program.

V
MEMBER RESOURCES

The name of this component has been changed from **Practice Enhancement** to avoid any confusion between its role within DAP and the broad area of practice management which is not part of DAP. The component remains devoted, however, to helping CDA members and their staff improve patient communication. It works to help members change patients' direct experience of dentistry in order to generate improved patient relations, greater receptivity to the idea of regular visits, and good word of mouth -- the key to new business.

Activities in this area will include:

- 1) Information Resources: "DAP Report"(s) and "Dental Awareness Program Update"(s) Special Communique Features

DAP will maintain and expand its information programming for members by increasing the number and frequency of DAP Reports, maintaining the monthly Update column in the Journal and by reporting in the Communique as and when necessary.

Discussions are underway with the CDA Journal on ways and means to integrate DAP information programming more effectively with the Journal and on an approach to generate corporate support in the form of advertising revenue to offset the cost of this expanded effort.

- 2) In-Office Patient Communication Resources: DAP Recall Program Kit, Fact Sheet Kit, Patient Education Resources, Promotional Materials

DAP will be creating and making available, on a low-cost basis, a variety of resources to help the dental office communicate more effectively.

- 3) Dental Awareness In The Office: A Seminar Series

There is a demonstrated interest at the society level in DAP training seminars. A general "Awareness In The Office" seminar is being developed for delivery at the 86 Convention. This program will be refined based on feedback and promoted to provincial associations and

dental societies for scheduling into 87 continuing education, professional development and/or practice management programs.

Once the Recall Kit is developed a special seminar will be developed around it for dentists and receptionists.

All seminars will be provided by DAP at competitive course rates.

VI PROVINCIAL ASSOCIATION LIAISON

Provincial Association Liaison was not a component of the original DAP Program. It becomes one now in recognition of the importance of maintaining the good working relationships that have developed with provincial associations in the area of awareness-type programming. Provincial associations are, as a group, showing an increasing interest in developing and/or expanding their province-specific activities. Most are working under CDA's "Good for Life" theme. All are interested in co-ordinating with DAP, and in having access to DAP resources and expertise.

Elements of this component will include:

1) On-going Communication: Written and Verbal

Each provincial association executive director (and designated elected officials as specified) will receive a bi-monthly update on DAP activities, coming opportunities for involvement, etc.

Personal contact, by phone, will take place on an ad hoc basis to augment written materials.

2) DAP National Planning Tour(s)

A DAP National Planning Tour is planned for Fall 86, to introduce the provinces to Phase Two, showcase DHM 87 and facilitate provincial activity planning. Such on-site working sessions have proven effective and would best be conducted on an annual basis. The budget for the basic program does not allow for CDA to provide such a service at DAP's expense during calendar years 87 and 88. The optional plans do allow CDA to cover this expense.

3) DAP Consulting/Training Services

Provincial Associations can access DAP professional services support of provincial activities on a fee-for-service basis. Media training workshops will continue to be available. Other consulting services can be made available through CDA for projects that complement DAP.

VII MARKET RESEARCH

Market Research will be expanded over the next two years in support of project planning and of Program monitoring.

Research is planned for both the general public and CDA members. Due to limited funds, the Program will have to find ways of conducting research inexpensively and of attracting subscribers from among provincial associations and/or corporations to allow representative studies to be executed.

Activity in this component would best include:

1) General Public Studies

Both qualitative and quantitative research to monitor public attitudes and to explore priority issues such as the image of the dentist, why people don't use dental benefits, why people don't go to the dentist.

2) CDA Members Studies

Again, the study should include qualitative and quantitative work. The quantitative studies will likely be conducted through telephone polling and questionnaires in the DAP Report on such issues as awareness of the Program, busyness, office communication activity and the like.

VIII CORPORATE SPONSORSHIP

The Corporate Sponsorship component remains the context within which DAP liaises with potential corporate sponsors and develops projects for sponsorship. While this activity remains of central importance to the program, it will likely require less financial commitment to achieve its ends over the next two years.

1) Sponsors Relations Program

The ongoing effort to identify and establish corporate sponsors.

2) Sponsorship Project Bank

This is geared towards selling corporations specific opportunities to become part of the CDA's marketing program. These opportunities must be presented to corporations in a form they will buy. An inventory of business presentations for priority CDA projects will be developed. When a project is sold, the money invested in the presentation can be recovered. The money is then cycled into the development of another sponsorship proposal.

IX
JOINT INITIATIVES

Through the **Joint Initiatives** component the CDA will work to make dental health a more important part of the established programming of a select number of organizations working in related fields, primarily at the national level: Health & Welfare Canada, CDHA, CDAA and Public Health Organizations.

In each case, working relationships will be expanded and/or developed around programs directly relevant to CDA's program objectives and needs.

1) Joint Initiatives Liaison

Consultation with key officials to identify project opportunities and the lobbying of these organizations to manage projects to fruition.

2) Project Proposal Presentations

Presentations and/or proposals will have to be prepared to solicit involvement. In the basic plan, emphasis will be placed on preparing application for Health & Welfare funding of special research and community programs.

BUDGET FRAMEWORK

At Council's request, three DAP budget options have been prepared for 1987-88. The basic budget reflects the minimum funding required to ensure DAP is able to build effectively on the foundations laid to date. It reflects a reduction in funding over the two years of \$90,000 at the rate of \$45,000/year. Two further options are presented, along with the benefits of each: one maintains the Program at its current average annual level. The other maintains the purchasing power of the current Program by factoring in inflation. All three allot resources according to the directions and priorities set by the preceding strategy and activity plans.

Council On Information Services reviewed all three options and decided to recommend a budget of \$225,000 in 1987 and \$250,000 in 1988.

Leverage:

All three DAP budget options are designed to exploit the leverage principle employed so effectively in the first two years of the Program. The fact remains that CDA must exploit the leverage principle to allow it to sustain a national program without breaking the CDA bank.

In the simplest terms, the DAP budget strategy is to do even more with even less. The net effect of this strategy is to provide CDA with a program that maintains 4:1 leverage for every association dollar spent.

The figures for both CDA costs and other funding in this budget framework are estimates only.

DENTAL AWARENESS PROGRAM:
BASIC PLAN

OVERALL BUDGET SUMMARY

COMPONENT	<u>1987</u>		<u>1988</u>	
	NET CDA\$ (000)	OTHER\$ (000)	NET CDA\$ (000)	OTHER\$ (000)
o Public Education	33.5	750	33.5	750
o Media/Public Relations	35	NIL	35	NIL
o Public Service Advertising	20	100	30	100
o Dental Health Month	75	40	75	50
o Member Resources	24	50	24	50
o Provincial Assoc. Liaison	7.5	12	21	12
o Market Research	20	30	20	30
o Corporate Sponsorship	2.5	NIL	2.5	NIL
o Joint Initiatives	7.5	NIL	9	75
TOTALS	225.0	982.0	250.0	1,067.0

DENTAL AWARENESS PROGRAM:

OPTION 1: \$275,000

Impact

The addition of \$50,000 to the annual budget enables the Program to expand activities in five components:

o Public Service Advertising: + \$ 10,000

These funds would allow the Program to increase the production value of advertisement and/or to consider a modest television campaign to augment print and radio.

o Member Resources: + \$ 16,000

These funds allow the Program to expand the member communication vehicles: DAP Report and DAP Updates.

o Provincial Association Liaison: + \$ 12,500

The additional funds allow for a national tour for one day working sessions with each provincial dental association on awareness-related planning.

o Market Research: + \$ 10,000

Funds allow the Program to expand research of CDA members' communication needs and to conduct limited qualitative research with the public.

o Joint Initiatives: + \$ 2,500

The basic budget allows for a highly selective approach to joint programming. These funds allow for a modest expansion of activity in the hope of generating further returns.

DENTAL AWARENESS PROGRAM:
OPTION 1

OVERALL BUDGET SUMMARY

COMPONENT	<u>1987</u>		<u>1988</u>	
	NET CDA\$ (000)	OTHER\$ (000)	NET CDA\$ (000)	OTHER\$ (000)
o Public Education	33.5	750	33.5	750
o Media/Public Relations	35	NIL	35	NIL
o Public Service Advertising	30	150	30	150
o Dental Health Month	75	40	75	50
o Provincial Assoc. Liaison	19	12	19	12
o Member Resources	40	75	40	75
o Market Research	30	30	30	30
o Corporate Sponsorship	2.5	NIL	2.5	NIL
o Joint Initiatives	10	NIL	10	75
TOTALS	275.0	1,057.0	275.0	1,142.0

DENTAL AWARENESS PROGRAM:

OPTION 2: \$300,000

Impact

The addition of a further \$25,000 to the annual budget enables the Program to further expand activities in two priority components:

o Public Service Advertising: + \$ 15,000

To increase production values and to intensify media liaison. These two activities could increase exposure by up to \$100,000.

o Market Research: + \$ 10,000

To allow for the videotaping and packaging of focus groups for use as dentist education tools.

DENTAL AWARENESS PROGRAM:
OPTION 2

OVERALL BUDGET SUMMARY

COMPONENT	<u>1987</u>		<u>1988</u>	
	NET CDA\$ (000)	OTHER\$ (000)	NET CDA\$ (000)	OTHER\$ (000)
o Public Education	33.5	750	33.5	750
o Media/Public Relations	35	NIL	35	NIL
o Public Service Advertising	45	200	45	200
o Dental Health Month	75	40	75	50
o Member Resources	40	75	40	75
o Provincial Assoc. Liaison	19	12	19	12
o Market Research	40	30	40	30
o Corporate Sponsorship	2.5	NIL	2.5	NIL
o Joint Initiatives	10	NIL	10	75
TOTALS	300.0	1,107.0	300.0	1,192.0

INTERIM BUDGET:

OCTOBER 1 - DECEMBER 31, 1986

There is an interim period of three months between the end of the current DAP mandate and the beginning of the 87-88 Program. To maintain the continuity of the Program during this period, the Council on Information Services has recommended a budget in 1986 not to exceed \$45,000

These funds allow essential DAP activity to continue. They include, as well, the cost of a national Provincial Association tour which Council deems of vital importance for the continuing development of the DAP/Provincial Association liaison and for the effective planning of 87-88 activity.

Activity during the interim period will include:

o Members Resources

Creation and publication of monthly Updates in the Journal; creation and publication of a DAP Report and DAP Communique information.

o Provincial Association Liaison

National DAP Tour; Communication (Written and Verbal)

o Public Education

Implementation planning for 87-88

o Media Relations

Ongoing liaison and dissemination of media releases

o Sponsor Relations

Liaison for 87 sponsorship opportunities

o Joint Initiatives

Liaison with Health and Welfare and preparation of research grant application; liaison with CDHA on joint programming for 87.

o Public Service Advertising

Media placement liaison with print media for existing campaign.

INTERIM BUDGET:
OCTOBER 1 - DECEMBER 31, 1986

COMPONENT	NET CDA\$
o Member Resources	\$ 7,250
o Provincial Assoc. Liaison	12,500
o Public Education	6,250
o Media/Public Relations	9,000
o Corporate Sponsorship	2,000
o Joint Initiatives	4,000
o Public Service Advertising	3,000
 TOTAL INTERIM BUDGET ESTIMATE	 \$ 44,000

MEDIA COVERAGE UPDATE

APPENDIX II

DENTAL HEALTH MONTH

The following is an update of the media coverage component of the Canadian Dental Association's Dental Awareness Program from March - May 1986, focussing strongly on April, Dental Health Month.

It should be noted that most of the broadcast media coverage listed here is in Toronto, as it is difficult to monitor coverage in other regions without investing in a monthly monitoring subscription in each major city across Canada..

The list is divided into three areas:

Broadcast Coverage - Television

Broadcast Coverage - Radio

Print Coverage - Magazines & Association Publications

Additional Print Media coverage is recorded on the attached list of newspaper items which appeared nationwide during Dental Health Month.

BROADCAST COVERAGE - TELEVISION

CBC - "THE JOURNAL": April 1

8 minute spot, "Fluoride - Poison or Prevention?" with Drs. G. Nikiforuk, D. Butler-Jones, B. Williams.
Average Audience: (up to) 4,000,000

CFTO TV - Toronto - "TORONTO TODAY": throughout April
six different 2-minute spots with Dr. Dean Edell, including: New tooth reconstruction; Pain at the dentist's.
Average Audience: (not available)

CFCF TV - Montreal - "TOP OF THE MORNING": April 7
5-6 minute spot, discussion of periodontal disease with Dr. Jacinthe Larivé.
Average Audience: 21,000

THE LIFE CHANNEL - PAY TV: April 11
Phone-in and discussion program to be aired four times throughout April, with Drs. David Kenny and Dennis Wells.
Nationwide Broadcast.

CFCF TV - Montreal - "TOP OF THE MORNING": April 14
5-6 minute spot, discussion of geriatric dentistry with Dr. Rita Hurley.

CBC - "MIDDAY": April 16
5 minute spot with Dr. Sidney Golden discussing the causes, treatments and effects of periodontal disease.
Average Audience: 1,200,000

GLOBAL TV - Toronto - "FIRST NEWS": April 16
2 minute spot with Hamlin Grange discussing Dental Health Month and New Dental Techniques: clips with Drs. K. Serota and D. Kenny.

RADIO QUEBEC TV NETWORK (French) - Montreal - News: April 17
Interview with Dr. Jacinthe Larivé discussing periodontal disease and its prevention.
Average Audience: 500,000 (Quebec and the Maritimes)

CBC - "MIDDAY": April 17
5 minute spot with Dr. Dorothy McComb discussing Bonding and New Advances in Dentistry.

BROADCAST COVERAGE - TELEVISION (cont'd.)

CBC - "MIDDAY": April 18

5 minute spot discussing the latest advances in dentistry including New Corrective Braces - Dr. Dana Colson.

CBC - "THE JOURNAL": April 19

5 minute spot re: Controversy over the use of mercury amalgams, including comments from Drs. Murray Vimy and Sheldon Newman.

CBC - "MIDDAY": April 23

same as the April 19 article on "THE JOURNAL".

CBC - "THE JOURNAL" ("The Diary"): April 23

2 minute spot featuring new dental technologies including an electronic cavity detector, liquid solution that breaks down decay and U. of T. research n a varnish that kills bacteria.

CFCF TV - Montreal - "TOP OF THE MORNING": April 25

5-6 minute spot with Dr. Katz discussing 'pain management'.

CHCH TV - Hamilton - "CHERINGTON": April 29

30 minute phone-in and discussion program with Dr. Tom Balanyk
topics covered: latest trends in preventive dentistry;
fluoridation; dental research.

CFTO TV - Toronto - "TORONTO TODAY": April 29

2 minute spot covering fluoridated mouthwashes and their effect on tooth decay.

GLOBAL TV - "FIRST NEWS": April 30

2.5 minute report on the new tartar-fighting toothpastes which were launched in Canada the previous day. Clips include company reps and Dr. John Speck.

CITY TV - Toronto - CITYPULSE NEWS": April 30

A report on Canada becoming the new battleground for the tartar-fighting toothpastes, (Crest and Colgate).

CFTO TV - Toronto - "TORONTO TODAY": May 12

1.5 minute report by Peter Emerson on Dental Implants/
anchor aids for the Denture Wearer.

BROADCAST COVERAGE - RADIO

CKFM - Toronto - "FOCUS": March 10

5 minute spot with Stu Hill discussing 'dentalphobia' and how to overcome it.

CBC AM: March 10

Interview with Dr. Trevor Lyons discussing periodontal disease and smears.

CKO RADIO NETWORK - "THE MEDICAL FILE": March 31-April 3

Four different 2-minute spots announcing Dental Health Month and discussing different dental health issues with hosts George Price and Alan Richards.

Average Audience: 100,000 (including broadcasts to: Halifax; Montreal; Ottawa; Toronto; London; Calgary; Edmonton; Vancouver)

CBC AM - "RADIO NOON": April 2

50 minute phone-in and discussion show with host David Schatzky interviewing Dr. Barry Korzen. Topics were Dental Health Month and answers to various dental questions from listeners.

CBC AM - "FRESH AIR SHOW": April 1

1-2 minute mention that April is Dental Health Month with host Bill MacNeil.

CBC AM - "DAYSHIFT": April 10

5 minute spot with hostess Erica Ritter discussing dental health 'true and false' statements also 'myths about cavities'. Dr. Bill Hettenhausen is to be a regular on the show in order to cover a number of dental health issues over a series of interviews.

Average Audience: 95,400 (national coverage)

CBC AM - "THE MEDICINE SHOW": March 5, March 12

Two 30-minute features with host Jay Ingram which covered: tooth decay; tooth care; overcoming the fear of dental treatments; the mercury content of amalgams.

Average Audience: 102,400 (national coverage)

CJCL - Toronto - "MORNING SHOW": Throughout April

Host Tom Fulton made frequent mention of Dental Health Month throughout April - often using "The Second National Dental Health Checkup" Magazine Supplement and the "Support Your Teeth" Poster for facts and tips. He focussed on gum disease and preventive items.

BROADCAST COVERAGE - RADIO (cont'd.)

CKO RADIO NETWORK - "COVER TO COVER": April 17

10 Minute interview with Dr. Brad Holmes, discussion covered Dental Health Month and dental health topics including questions from "The Second National Dental Health Checkup".
Nationwide Coverage.

CBC AM - "DAYSHIFT": April 24

10 minute interview with Erica Ritter hosting the last in a series of three shows on dental topics discussed by Dr. Bill Hettenhausen: Wisdom teeth; Dental cosmetics. Ms. Ritter will be doing another series with Dr. Hettenhausen which will air over the next couple of months and continue to re-run during the summer months.
Average Audience: (up to) 100,000

CBC AM - "METRO MORNING": April 25

5 minute live interview by Joe Côté with Dr. John Speck discussion focussed on various dental hygiene topics.
Average Audience: 150,000 (note: CBC's 2nd largest audience)

RADIO DIFFUSION MUTUELLE CANADA - Montreal - (French): Mid-April

15 minute interview with Dr. Marc Boucher during which several different aspects of dental health care were covered.

CHUM FM - Toronto: April 28

Interview with Dr. Tom Balanyk discussing the tooth decay-prevention properties of fluoridated mouthwashes.
Average Audience: 1,200,000 (note: Halifax/ Toronto/Winnipeg)

Q RADIO NETWORK - "NEWFOUNDLAND TODAY": May 7

Two 8-minute interviews with Dr. Toby Gushue discussing Bonding and periodontal disease.
Average Audience: 300,000

Q RADIO NETWORK - "NEWFOUNDLAND TODAY": May 16

Brief spot interviewing Dr. Richard Price about the new tartar-fighting toothpastes and their claims to have an effect on dental health.

CBC AM - Ottawa: May 24

Dr. Ralph Barolet interviewed about the tartar-fighting toothpastes which have recently appeared on the Canadian market.

PRINT COVERAGE - MAGAZINES/ASSOCIATION PUBLICATIONS

TODAY'S HEALTH: March

"Dental Decay in Infants" - An article written by Dr. William McNiece discusses: heredity; developmental disorders; diet and nutrition; prevention.

Circulation: 29,000

TODAY'S PARENT: March

Dentistry column, "April is the month to sink your teeth into a preventive dental programme for the whole family", written by Dale Anne Freed in conversation with Dr. H. Tupholme, Dr. A. Peltoniemi and Dr. T. Purves. Subjects covered are bonding (pit and fissure sealants), fluoride, advice for parents.

Circulation: 138,230

National Council of YMCA's Canada Bulletin/'Y' Canada: April

Enclosed with the mailing of their publication to 225 Y's were 5 Fact Sheets and the "Support Your Teeth" poster for display and distribution.

Circulation: Nationwide

Canadian Pharmaceutical Association Journal: April

Article on Geriatric Dentistry

Circulation: 12,000

PROTECT YOURSELF Consumer Magazine: April

"Finding a Dentist" - a six page article which includes: how to look for a dentist and what to expect when you've found one; costs of dental care; the dental exam; prevention.

Circulation: Nationwide (subscription-only in Ontario)

CANADIAN JOURNAL OF PUBLIC HEALTH: March/April

Articles on: "Bottle Caries"; "Oral hygiene habits and periodontal knowledge in a group of Canadian Adults - a pilot study". The latter is written by Dr. J.N. Hoover and Dr. J.J.Tynan, discussing the results received from a survey given in Saskatoon.

Circulation: 4,000

TIME Magazine (Canada): April 7

An 8-page special section containing articles on: periodontal disease; plaque; how to brush, floss, massage (illustrated); nursing bottle decay; sealants; cosmetic dentistry; fluoride; proper care.

Circulation: 460,000

PRINT COVERAGE - MAGAZINES/ASSOCIATION PUBLICATIONS (cont'd)

ANNALS of the Royal College of Physicians & Surgeons of Canada
The "Are Your Pearly Whites Heading For The Pearly Gates" advertisement was published in their March/April issue.
Circulation: 22,830

TIME Magazine (Canada): May
A full page within a 12-page health insert appeared complete with the "Good For Life" logo and a message from Dr. Brad Holmes.
Circulation: 460,000

CHATELAINE: April
A twelve-page supplement, "The Second National Dental Health Checkup", a 20-question quiz aimed at adults is the flagship vehicle for this year's Dental Health Month.
Estimated readership: 6,000,000 (an additional 350,000 copies distributed through dentists' offices and pharmacies across Canada.)

CANADIAN CONSUMER: May/June
In the "Letters to the Editor" section will be a letter from Dr. B.W. Holmes, thanking the magazine for the article on 'The Plaque Battle' which appeared in February 1986.
Circulation: 160,000

Dental Health Month 1986: clippings received by 5 June 1986

Total to date: 1221 items (464 DHM articles, 691 general articles, 66 filler ads). We anticipate 150-250 more.

1. Local DHM Activities and Events.....Total 254

Newfoundland	0
Nova Scotia	12
Prince Edward Island	7
New Brunswick	10
Quebec	39
Ontario	157
Manitoba	2
Saskatchewan	7
Alberta	7
British Columbia	17
Northwest Territories	1

2. National DHM Campaign.....Total 71

Newfoundland	3
Nova Scotia	1
Prince Edward Island	5
New Brunswick	3
Quebec	5
Ontario	27
Manitoba	1
Saskatchewan	6
Alberta	12
British Columbia	8

3. Dental Health Information and Advice (from DHM releases or mentioning DHM).....Total 139

Newfoundland	4
Nova Scotia	5
Prince Edward Island	3
New Brunswick	16
Quebec	45
Ontario	43
Manitoba	1
Saskatchewan	2
Alberta	15
British Columbia	5

4. General articles (not specifically DHM-related, but collected over this period).....Total 691

By subject:

Dental Health Advice*	161
Dental Disease*	69
Techniques, Improvements*	73
Policy Issues	140
Local Dental services	77
Fluoridation	70
Professional Affairs	79
Dental Care Products	22

* Almost all the articles in these categories were generated by the **Good for Life** program (or strongly express its messages.)

5. Filler Ads: 66 items

	Don'tWait	Long	Keepers	Age25	Don'tRush	Alert	Adults	Chance	Pearly
NF	1							1	
NS								1	
PEI						2			
NB	1				1				
PQ			1						3
ON	7	2		1	2		1	5	
MB	1	1		1		3			2
SK	1	1				1		1	1
AB	3	1			2	4	7	2	
BC	1	1			1				2
Totals	15	6	1	2	5	11	8	10	8

COUNCIL ON INSURANCE AND INVESTMENT

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Members: CDSPI Board of Directors

Dr. G. Anthony, Atlantic Provinces
 Dr. G.F. Copithorne, British Columbia
 Dr. R. Dupont, CDA Representative for Québec
 Dr. C.R. Hill, Manitoba and Saskatchewan
 Dr. D. Montminy, Québec
 Dr. R.L. Moran, CDA Representative for Ontario
 Dr. R.L. Rasmussen, Alberta
 Dr. R.R. Schiewe, Ontario

Brig.-Gen. J.N. Wright, CDA Executive Liaison

Members: Management Committee, CDSPI

Dr. J.E. Durran, President, Burlington
 Dr. R.L. Moran, Treasurer, Toronto
 Dr. M.D. Charendoff, Secretary, Toronto

This report includes all information that requires reporting and which has become available since April 4, 1986. The CDSPI Board met on March 7, 1986, and May 23 and 24, 1986.

Items Requiring Board Action

1. Malpractice Information to the Provinces

In 1984 the CDA charged CDSPI with the task of operating a Loss Prevention program on their behalf in relation to the General Insurance package. This related specifically to Malpractice, but also included the other three areas of coverage.

To date, the Board is aware of the projects that have been launched in the area of Malpractice, e.g. two Loss Prevention Seminars, Loss Prevention bulletin, video, newsletter articles, etc.

As our carrier, Guardian has confirmed their strong support of any Loss Prevention program and virtually insist that this be continued as part of our commitment to work with them on this program. Only through a concerted effort in this area can the Malpractice program continue.

COUNCIL ON INSURANCE AND INVESTMENT

At the Loss Prevention seminars, every effort has been made to involve the corporate members as much as possible in Loss Prevention. Each provincial licensing body has a responsibility to police its licence holders, as well as to protect the public. One of the areas of continual correspondence and input with the provinces was that of providing them with names/statistics regarding Malpractice claims.

Originally, names were provided, but legal advice informed us that this could not continue. Comments regarding ways names could be forwarded (placing wording on memoranda, including statements in the policy, changing the application form), have all been addressed. The bottom line was that, unless a dentist gave permission to have the material on claims given to the provincial association or licensing body, Guardian as the insurer did not want to take the risk. Consequently, all names are confidential (see legal opinion letter of August 12, 1985, attached as Appendix A).

APPENDIX A

The Management Committee has discussed this matter extensively over the past months and feel that part of the solution could be a move to incorporate, as part of the policy wording, a "no information to the provinces - no coverage" attitude with participants.

The Management Committee also strongly feels that the provinces should be looking at ways to better control claimants within their province without involving CDSPI; namely, through the reporting of claims to the licensing body as part of the licensing procedure.

However, it remained desirable for CDSPI, as the CDA Council on Insurance and Investment, to recommend action to be taken by the policyholder (the CDA) to protect its plan.

Prior to making any recommendation, a letter was sent to each provincial licensing body which said, in part:

"....We realize that we can provide you with certain information, but are not permitted to provide you with other forms of information. We would like you to tell us what you would like to receive from CDSPI in relation to Malpractice claims information if we were in a position to provide you with that information".

COUNCIL ON INSURANCE AND INVESTMENT

Each provincial Director was copied with this January 15, 1986, letter.

The responses from the provinces that replied are briefly summarized below:

Newfoundland	-	Wants names.
New Brunswick	-	As much information as possible, but "particularly the name of the dentist".
Nova Scotia	-	Name and area of concern.
P.E.I.	-	No response as of April 28, 1986.
Québec	-	No response as of April 28, 1986.
Ontario	-	N/A
Manitoba	-	No response as of April 28, 1986.
Saskatchewan	-	Current statistics plus name and disposition.
Alberta	-	Current statistics plus name of insured having numerous claims.
B.C.	-	(Their letter was received before our written request went out) A paragraph of information to provide points at issue on various claims. Names are not as important as information about the claims in greater detail.

It appears reasonably clear from the responses that the wishes of the majority of the respondents are:

1. Current statistics continue.
2. Provide names.

Providing the statistics is no problem and, in continuing, we confirmed our position that most licensing bodies wished names of claimants in order to assist with Loss Prevention.

As a result of the extensive review of this item, CDSPI recommends to the CDA Board of Governors:

RESOLVED:

86.99 **THAT provinces requiring specific information on malpractice claims place the responsibility for disclosure on the dentist, and make this a requirement of licensure.**

ADOPTED

COUNCIL ON INSURANCE AND INVESTMENT

The Council on Insurance believes that the ultimate responsibility for the awareness of the Malpractice condition of each Province rests with the provincial licensing board. Therefore, it seems logical that each Board would implement a policy which would require each dentist to declare his/her particular Malpractice condition, coincident with the annual re-licensing procedure. This is the intent of the Motion.

2. Accumulation of Days to Satisfy Elimination Period Requirements for LTD and Office Overhead Benefits

CDSPI recommends to the CDA Board of Governors:

RESOLVED:

86.100 THAT the guidelines with regard to accumulation of non-consecutive days for the satisfaction of an elimination period under the long-term disability and office overhead contract, be as follows:

<u>Elimination Period</u>	<u>Guideline</u>
Less than 30 days	Must be consecutive days.
30 days	Non-consecutive days for the same or related disabilities, provided that no interruption in the accumulation is longer than two weeks. Maximum period for accumulation to be 90 days.
90 days	Non-consecutive days for the same or related disabilities, provided that no interruption in the accumulation is longer than two weeks. Maximum period for accumulation to be 180 days.

ADOPTED

The passing of the above Motion implements guidelines which are competitive within the industry and provides fair treatment to the participants.

3. CDSPI Report to the CDA - Timing of Distribution to the Provinces

This subject has been brought to our attention for the following reason: the CDSPI report is sent to the CDA Executive approximately 14 weeks prior to the CDA Board Meeting at which it is discussed. After the CDA Executive reviews the report, it is included in the CDA Board Book and circulated to the provinces, with approximately a three-week lead time before discussion at the CDA Board. If a province schedules a meeting of its representatives to the CDA Board, and it becomes apparent that there is some material in the CDSPI report which requires clarification, that province may find it necessary to call in its Director for consultation. Time becomes a governing factor in the province's ability to deal effectively with the material in question.

Since the CDSPI report becomes a CDA document after submission, it appears that the CDA should be requested to respond to the above problem.

Executive Council has directed that the Management Committee will consider this item and make any adjustment necessary to the present procedure.

4. Presentation of CDIP and Other Services to Other Organizations

The Executive Vice-President brought to the attention of the Board a situation that has been developing in connection with the Ontario Dental Nurses and Assistants Association. In addition, his concerns also related to the advice of our solicitors pertaining to being perceived as providing insurance programs "to the public". You will recall that when we approved the offer of the dentists' staff plan, the offer was advised by Ms. Beth Moore as to be contained within the dental profession and, therefore, dentists were to receive the promotional material and they, in turn, would deal with their own staff.

As you are aware, auxiliary staff, if they work for an eligible dentist in excess of 20 hours a week, are eligible to participate in CDIP. Consequently, CDSPI obtains invitations from such organizations as the Ontario Dental Nurses and Assistants Association to attend their conventions and, in fact, even attend their Board Meeting. Auxiliaries also attend provincial and national conventions, stop by our booth, and receive our promotional material.

Although these eligibility guidelines are contained in our material, there currently is nothing formal in place which permits CDIP to be offered to the auxiliaries.

COUNCIL ON INSURANCE AND INVESTMENT

Consequently, if challenged or questioned, we could be perceived as offering our programs "to the public".

In order to clean up this particular area and permit us to continue offering our programs to other organizations that are directly related with the dental profession, CDSPI recommends to the CDA Board of Governors:

RESOLVED:

- 86.101 THAT the CDA amend its eligibility requirements for participation in CDIP to include members of any organization that specifically serve organized dentistry.

ADOPTED

DIRECTION

The Board requested that a list of organizations covered by this motion be prepared and re-submitted at a future meeting.

The eligibility requirements would also be that of working for an eligible dentist, in excess of 20 hours per week.

5. Accidental Death and Dismemberment - Recommended Policy Changes

(a) Administration Problem - Termination of Coverage Provision

Currently under the policy is the following wording:

"On the premium due date following the date the insured person ceases to be associated with the policyholder in a capacity making such person eligible for insurance hereunder, provided however, that a dentist may continue to be insured hereunder only if he continues in his profession on a full-time basis in Canada, subject to paragraph (a), (b), (c) above and all other provisions of the policy."

COUNCIL ON INSURANCE AND INVESTMENT

In administering this section of the policy, an interpretation of the wording has been made which states that an individual may continue his/her AD&D coverage only if working full-time in dentistry in Canada. The situations that were developing were as follows: What would happen if an individual is on leave of absence and goes outside of Canada? Does this mean that the coverage would have to be given up? If an individual takes a leave of absence from dentistry to, for example, return to school, does this affect their coverage?

Another area of concern related to the fact that if the policy ceases when an insured reaches 70 years of age, what happens if the person retires, even partially? They are not continuing in their profession on a full-time basis.

It was decided to investigate the current wording further to see whether or not it was standard, and/or how it could be improved. We received a letter from TPF&C, dated February 4, 1986, indicating that Seaboard would be willing to adjust the policy, as outlined in the letter. After reviewing this letter, the Management Committee felt that the six-month limitation was too restrictive, and as a result of further enquiries, the TPF&C letter of March 12, 1986, extended this for a period of up to three years.

APPENDIX B

CDSPI therefore recommends to the CDA Board of Governors:

RESOLVED:

86.102 THAT the termination of coverage provision under the AD&D policy be extended to include a continuation of coverage under the following circumstances:

1. the participant must be a member of the association, and
2. must be under 70 years of age, and
3. must be a Canadian resident.

Leaves of absence for dentists or students who are either practising, teaching, or attending graduate school out of the country may be for a period of up to three years, with any further time extension subject to approval by the insurer.

ADOPTED

(b) Premium Review - Plan Improvement

Enquiries were made with respect to the competitiveness of our present AD&D coverage and the premium charged. TPF&C confirmed that the rates are competitive and, at a meeting with Seaboard Life, they indicated that there could not be a rate reduction because of the current experience. They did however, state that there were one or two products which were being considered. The following Motion, which defines an education benefit, gives a slight increase in available benefit to a limited group at no increase in premium; therefore, CDSPI recommends the adoption of the following Motion:

RESOLVED:

- 86.103 THAT, effective January 1, 1987, a special education benefit be contained as part of the current AD&D policy on the basis that an education benefit is payable if an insured person dies by accidental means and there are surviving children attending secondary school. The amount of the benefit would be available to those participants whose principle amount of coverage is \$150,000 or more, and the amount of the benefit would be \$2,000 per child, payable each year for a maximum of four years for as long as such child is attending college or university. The benefit would be included at no additional premium.

ADOPTED

6. General Insurance Coverage for 1987

At our last Board Meeting, our General Insurance broker presented his report concerning renewal of the CDIP General Insurance packages for 1987. A copy of this report is attached as Appendix C.

APPENDIX C

As a result of this report, CDSPI recommends to the CDA Board of Governors:

RESOLVED:

86.104

THAT:

1. The repeater deductible be removed from the malpractice policy as of December 31, 1986.
2. A \$500 deductible payable on each loss where payment is made to a third party be implemented as of January 1, 1987.
3. An umbrella liability option be included in the CDIP general insurance package as of January 1, 1987.
4. Wordings, rates and coverage changes, as outlined in this report, be accepted to take effect January 1, 1987, including any wording, rate or coverage alterations at a future date being changed by reinsurers as noted in the report.

ADOPTED

7. Basic Life Plan - Distribution of Surplus Generated in 1985

Following the CDSPI Board's approval in December of a formula regarding distribution of surplus, TPF&C conducted their audit of the 1985 Plan year, confirmed the surplus figures and prepared a report outlining their recommendation for the amount of surplus that could be distributed. Attached as Appendix D is their report.

APPENDIX D

The CDSPI Board reviewed the Report and recommends to the CDA Board of Governors:

RESOLVED:

86.105

THAT an amount of approximately \$658,000 of life surplus be distributed as January 1, 1987, on the basis of a premium credit on the 1987 invoices, for insurance in effect as of August 23, 1986, with such distribution being equal to 23.8% of the gross life premium otherwise due, and that this percentage figure be used in this calculation.

ADOPTED

Items for Information - Not Requiring Board Action

1. Corporate Structure of CDSPI Board

The CDSPI Board considered the various alternatives which have been proposed for the restructuring of the present representation to the Board at its May Meeting.

As a result of that discussion, the following recommendation will be presented at the Annual Meeting of members of CDSPI, which will be held on August 23, 1986, immediately following the conclusion of the CDA Board Meeting.

THAT the Management Committee members of Canadian Dental Service Plans Inc. shall be appointed on an equal basis as officials of the Board, and will not be voting directors of the Board, but be entitled to attend all meetings of the Board.

and further,

THAT the Board of Directors of Canadian Dental Service Plans Inc. be structured in the following manner:

1. The Provinces of British Columbia, Alberta and Québec will each appoint one (1) voting director.
2. The Province of Ontario will appoint two (2) voting directors.
3. The Province of Manitoba and the Province of Saskatchewan will each appoint a representative to the Board of Canadian Dental Service Plans, Inc. One of these representatives shall be the voting director; the other shall be an observer.
4. The Provinces of Prince Edward Island, Newfoundland, Nova Scotia and New Brunswick will each appoint a representative to the Board of Canadian Dental Service Plans Inc. One of these representatives shall be the voting director; the remaining three representatives shall be observers.

5. The Canadian Dental Association will appoint two voting directors to the Board of Canadian Dental Service Plans Inc. One of these directors shall be appointed at large by the Canadian Dental Association. The other voting director shall be appointed from its Executive Council; this appointee will serve as Executive Liaison to the Canadian Dental Service Plans Inc. Board.

Hopefully, the above represents a satisfactory compromise to all concerned.

2. 1985 Annual Experience and Statistical Report

This report is 135 pages long, and includes the results of the year 1985 for both benefit and general insurance lines that are made available through CDIP. Each province receives a copy of its own results.

Highlights are difficult to segregate, but have been selected as follows:

- (a) The Life program showed an increase in premium received of approximately 9.5%. The transfer to Contingency Fund - which might be construed as the bottom line was \$832,110.00.
- (b) The Disability premium showed an increase of 10.71%. The transfer to the Contingency Fund was \$932,000.00, which indicates that the premium is accurate when you observe that the gross premium for Long Term Disability and Office Overhead totals 6.2 million dollars. In this area there is a statistic which is going to require careful monitoring - i.e. there was a decrease in the number of participants in the Office Overhead plan to the extent of a 5.5% drop in numbers. This may reflect a pricing problem in that area. The problem is being investigated.
- (c) Malpractice experience displays a loss ratio of 109.1%, i.e. for every dollar of premium received there was paid out or reserved \$1.09. The other areas of General Insurance performed at an acceptable level of loss experience.
- (d) The average coverage for Life Insurance increased to \$156,000.00, as opposed to \$90,000.00 in 1978. However, this is not a doubling of coverage in the Life Program, whereas for the Office Contents and Practice Interruption coverages, the dentists have prudently more than doubled their coverage.

COUNCIL ON INSURANCE AND INVESTMENT

- (e) Finally, there has been a definite trend in the age distribution of our dentist participants. In 1978, there were 41% in the age band between 25-34. In 1985 there were only 31% in that same age band. The older age bands have had a proportionate increase in percentages.

3. CDA RSP

The momentum that was apparent in 1985 has continued into this present year. Total contributions for the month of March 1986 were \$1,042,119.00, compared to \$136,467.00 for March 1985 (see Appendix E (i), (ii), attached, for further details).

APPENDIX E

We are continuing to examine an investment vehicle which would satisfy the needs of those dentists who wish to invest in addition to their contributions to their RSP.

4. Retirement Counselling

Seminars have been held in Vancouver, Calgary, Winnipeg, and Toronto. The evaluation forms that have been distributed at each seminar have been very complimentary. Dates have been booked for Newfoundland, Halifax and Montréal.

5. Dental Office Management System - Computers

The Board of CDSPI has re-examined our involvement with computer services and is more than ever convinced that this is an area in which we can be of service to the dentists of Canada. To this end we are now engaged in developing the software which we know is necessary to provide a bench mark system for our dentists.

6. By-law Problem re Eligibility

Late in 1985, CDSPI was contacted concerning certain sections of the by-laws relating to forfeiting eligibility (e.g. Article #6, Section 3 (c), which states, "Affiliate members will not be caused to forfeit eligibility to Association-sponsored insurance and investment plans while under temporary disciplinary suspension of licence", and Section 6 - Associate Members - "An Associate member in good standing shall have the same rights and privileges as an Affiliate member.").

We reviewed this and wish to bring to your attention the fact that these sections create problems where it is required by the insurer that eligibility standards be met in order to maintain coverage. One of the

eligibility requirements is membership in good standing with the CDA or corporate sponsoring bodies. We draw this to your attention in order that the CDA may wish to direct their Council on Constitution and By-laws concerning this matter.

7. Claims Procedures

At an Ontario Dental Association Insurance Committee Meeting, procedures relating to time frames in sending claims was questioned. A report (Appendix F) was presented to the ODA and we feel that this would be of interest to the CDA Board of Governors' members.

APPENDIX F

8. Negotiations on Benefit Plans

Usually contained in this report are our Board's recommendations relating to the Benefit Package of the CDIP (Life, LTD, Office Overhead, and AD&D). Our consultant's report on this renewal is not being presented to us until mid-July, and will be on the Agenda for our Board Meeting in Halifax. Recommendations from that report relating to contract renewal and proposed plan changes for 1987 will have to be considered by the CDA Executive following that meeting. Again, as with the General insurer, early commitments are no longer a "given", as we have been used to in the past. The industry is changing, and we find we must adjust accordingly.

Finally, since this report represents the CDSPI Annual Report to the CDA Board, I want to thank all those who help us to do what we do. Your co-operation and assistance is appreciated.

Respectfully submitted,

John E. Durrant, D.D.S.
Chairman, Council of Insurance and
Investment

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Insurance and Investment with appreciation.

BELL, TEMPLE
BARRISTERS & SOLICITORS

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CAMERON C. R. GODDEN
DONALD G. CORMACK
DAVID A. TOMPKINS
STEVEN R. BELL
PETER H. LAMPREY
BRIAN E. LUCAS
GLENN M. ZAKAIS
PAUL S. LENARDON
RALF R. JARCHOW
HUGH G. BROWN
WILLIAM E. FODEN

August 12th 1985

Guardian Insurance Company
of Canada
P.O. Box 4096
Station A
TORONTO, Ontario
M5W 1N1

Attention: Mr. Peter N. C. McLuskey

Dear Sirs:

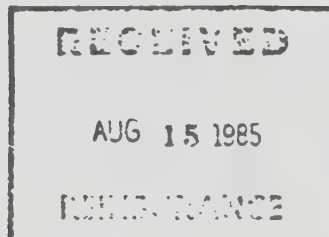
Re: Guardian Re Canadian Dental

We have your correspondence of August 8th 1985 and have noted your comments.

We do not see any reason why the clause with regard to the release of claims information should not be incorporated into the policy as you suggest, and in our opinion this is a good idea regardless of what ever other steps you may take to bring this matter to the attention of the dentists and to obtain acknowledgement from them.

Also, by inserting the suggested clause into the application for new members, you will effectively obtain their signed agreement to the release of any information and that should forestall any complaints they might have in the future if information is passed on.

We do have some slight reservation with respect to the suggestion that the contemplated change in policy wording be drawn specifically to the attention of existing members along with a request for a signed acknowledgement of the change. Our concern is that this will perhaps place undue emphasis on the fact that claims information may be released



to various supervisory and regulatory bodies. By pointing this out to existing insureds as something new and specifically requesting an acknowledgement, you will effectively force the insured to consider the change and to decide whether he is content with it.

We had originally considered that it might be preferable to forward to existing members, a renewal package consisting of a copy of the policy along with the usual memorandums of insurance, but as well enclosing the suggested form advising of policy changes and a routine application form requesting renewal for the 1986 year. We had not considered the problem with existing members being required to report potential claims as required on the application and after discussing this aspect with you, we can understand why some form of acknowledgement would be preferable to a more formal application.

In our opinion a signed acknowledgement by a dentist of the policy term permitting release of claims information to appropriate licensing bodies would be sufficient protection for your company and would clearly place the dentist in the position where he has full knowledge of that term of the policy and has agreed to accept insurance from you on that basis. You have made full disclosure to him of your intention to release information and it will be difficult for him to later say either first of all, that he did not notice that term in the policy and was not aware that it was part of the contract of insurance.

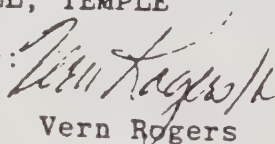
You have pointed out that in all probability the majority of the insured dentists would be quite happy with such a term in the policy and the fact that it would to some extent monitor their own profession against the dentist who was not practising up to ordinary standards. Certainly bringing this potential for release of claims information to the attention of the profession generally as a term of the insurance coverage, would make it part of the general understanding of the profession that information might be released and would make it less likely for some particular dentist to object when it occurs. In all probability the more generally well-known this particular term becomes within the profession, the less likely any particular dentist will complain when it occurs.

We hope these comments may be of some use to you in your consideration of the problem and if we can clarify our comments for you in any way or if you have any questions, please feel free to contact the writer at your convenience and we will be happy to discuss them with you.

Yours very truly,

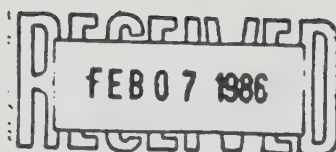
BELL, TEMPLE

Per:



Vern Rogers

VR/b



TOWERS, PERRIN, FORSTER & CROSBY
 250 BLOOR STREET EAST, SUITE 1100
 TORONTO, ONTARIO M4W 3N3
 (416) 960-2700

DIRECT DIAL

960-2802

February 4, 1986

Our Ref: 00669/008

Mr. K. Rudd
 Seaboard Life Insurance Company
 P.O. Box 34039
 2165 West Broadway Avenue
 Vancouver, B.C.
 V6K 4N4

Dear Mr. Rudd:

Re: Canadian Dental Association
Termination of Coverage Provision

This letter is a follow-up to our telephone conversation of January 31, 1986 with regard to the CDA basic AD&D policy.

We have received agreement from Seaboard that the Termination of Coverage provision can be extended to include a continuation of coverage under the following circumstances:

1. The participant must be a member of the Association, and
2. must be under 70 years of age, and
3. must be a Canadian resident.

Leaves of absence of up to 6 months would be acceptable for purposes of continuing coverage.

Unfortunately, after receiving Seaboard's agreement in principle to the forgoing conditions, we were made aware that the 6 month limitation for leaves of absence would not be sufficient for dentists or students who are either practising, teaching or attending graduate school overseas.

Ideally, CDA would like to have no time limitation whatsoever for the circumstances outlined in the preceding paragraph; however, if this is not acceptable to Seaboard, a three year period would cover most eventualities. If a participant requires a further extension, presumably, it could be arranged by means of application to Seaboard for such extension prior to leaving Canada.

The six month limitation for other types of leave remains acceptable.

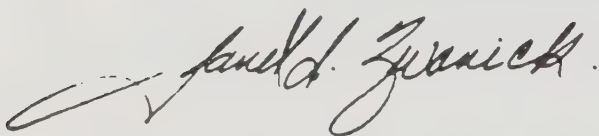
TOWERS, PERRIN, FORSTER & CROSBY

To: Mr. K. Rudd
Page: Two
Date: February 4, 1986

We look forward to receiving your comments. In the meantime, if you have any queries please do not hesitate to contact either Ken Ransby or me.

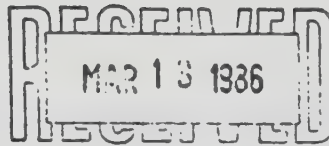
Yours very truly,

TPF&C LIMITED

A handwritten signature in dark ink, appearing to read "Janet I. Zwarick". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

Janet I. Zwarick
/kb

cc. K.D. Butler, CDSPI
K.T. Ransby, TPF&C



TOWERS, PERRIN, FORSTER & CROSBY
250 BLOOR STREET EAST, SUITE 1100
TORONTO, ONTARIO M4W 3N3
(416) 960-2700

DIRECT DIAL

960-2802

Our Ref: 00669/008

March 12, 1986

Mr. Kingsley D. Butler
General Manager
Canadian Dental Service Plans Inc.
2 Lansing Square, Suite 600
Willowdale, Ontario
M2J 4Z3

Dear Kingsley:

Re: Accident Insurance - Termination Provisions

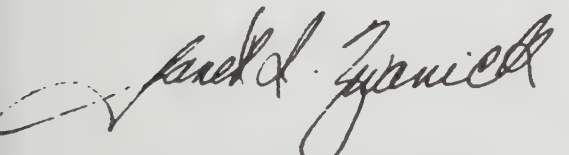
Further to my letter to Ken Rudd of February 4, 1986, I wish to advise that Seaboard has agreed to a relaxation of the termination provision contained in the AD&D policy.

The provision may be amended to permit an extension of coverage for a period of up to three years for dentists or students who are either practicing, teaching, or attending graduate school out of the country. Any further extension would be subject to approval by Seaboard.

Would you please confirm that you wish to proceed with the amendment to the policy.

Yours very truly,

TPF&C LIMITED


Janet I. Zwarick
/bj

cc. K.T. Ransby

1987 RENEWAL NEGOTIATIONS

FINAL REPORT

FOR

CANADIAN DENTAL SERVICE PLANS INC.

PREPARED BY:
F. Wallace Clancy & Son Ltd.
May 1st, 1986

GENERAL MARKET CONDITIONS

Canadian Architects, Lawyers, Directors and other professionals have discovered, with dismay, that they all have something in common: They are all searching for coverage in an insurance wilderness.

To some extent the problems Canadian Professionals face have been caused by the reaction of the international insurance marketplace to U.S. events. Over the past few years, Americans have launched a multitude of law suits against professionals and the courts have given multi-million dollar sums to successful litigants.

Canadian Professionals have not been as severely bludgeoned as their U.S. counterparts by premium increases. Court awards in Canada have not escalated to U.S. levels and Canadians, generally speaking, are still less inclined to sue. However, Canadian Accountants, Lawyers, Doctors, Real Estate Brokers, Directors, Architects and Engineers, etc. are having to dig deep into their pockets as the shock waves roll North across the Border.

As the number of law suits and court awards increases, the fees paid by Canadian doctors into an insurance pool are escalating.

For Architects in Ontario, the incidents of claims has increased 50% in the past three years compared to the three years earlier. Premium rates have increased to a maximum of \$8.25 per \$100.00 of gross fee income in 1985 - 1986 from a maximum of \$2.90 per \$100.00 of gross fee income in 1984. Although Architects have been

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required by Ontario law since 1984 to purchase Professional Liability insurance, the rising costs forced the Association to ask the Government for a stay of execution. Architects now have until April 1987 to find coverage.

Even Real Estate Brokers are running into severe problems. Their premiums are expected to rise by 50% to 70% in 1986 and, depending upon the number of employees, the average residential Real Estate Broker will spend from \$400.00 to \$4,000.00 for \$500,000.00 coverage.

Premiums for Directors have gone up between 200% and 300% over the last three years. Also, unfortunately, the amount of coverage available to Directors has declined dramatically.

As everyone is aware there are more suits and more plaintiffs these days. Heightened awareness of legal rights and the celebrity of some very high awards are two factors that have brought more litigants into the courts.

To-day the fear in the insurance industry can be summed up in four words: "the deep pocket theory". The theory refers to judges or juries who have taken to awarding damages against whoever can best afford to pay.

Our civil justice system is becoming more liberal in the interpretation of negligence. Many courts seem to be more concerned with giving a benefit to the victim than determining the extent of fault of the parties involved.

Mr. Justice H. Krever of the Supreme Court of Ontario recently told a University of Manitoba audience that judges must sometimes practice "intellectual dishonesty" and make

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findings of negligence even if there was none because that is the only way a plaintiff can be compensated.

Much of the credit for the surge in litigation awards can be directly attributed to innovative lawyers. These lawyers produce more technical evidence and try out many new ideas. In the area of lost wages, for example, they have persuaded many judges that their plaintiff chances of promotion during their lost careers would have been excellent; thus more money.

One lawyer recently convinced a judge that the husband of a dead woman should be awarded \$920,000.00 to compensate for her loss of future income.

The insurance companies have also been hit hard by interest charges on the lump sum of an award dating back to the accident. It can amount to a very large sum if a case takes several years to come to court.

As far as the general public is concerned, the property-casualty insurance industry would not historically have been considered a high-profile industry. That is now changing.

Equally, the reinsurance was not a concern of the insurance buyer. Generally speaking, he did not know of it's existence. This, too, has changed.

Insurance Companies "sell" percentages of their claims-prone coverages to reinsurers as a risk-sharing precaution. Not only has the insurance buyer been made aware of the existence, purpose and importance of reinsurance, he has also become

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- 4

sufficiently informed to appreciate it's implications as they concern an insurer's ability to honor an insurance contract.

Reinsurance treaty negotiations for 1984 and 1985 showed reinsurers' determination to return to profitable operations by seeking tougher terms and/or withdrawing from business. That the most severe contractions and withdrawals of capacity, as well as the most dramatic price increases, fell on the liability classes merely attests that these classes caused the most serious problems. Indeed all such business, worldwide has come under close scrutiny.

The Canadian insurance marketplace is now in a period of readjustment. Price levels will have to increase in order to reflect the reality of the loss costs they have to support as well as the increased cost of reinsurance.

For the price of liability insurance to be reduced, changes, including legislative changes, will have to be considered. The cost of liability insurance is measured by the cost of claims paid in the past, claims now outstanding and claims that are predicted to have to be paid in the future. It is mainly insurers perceiving a lack of predictability of future claims experience that accounts for the volatile nature of the present liability insurance markets.

At this time we would like to point out that the insurance industry has had it's cycles and crises in the past and has survived them all. The solutions to each crisis just become more difficult as time passes since we are truly a society highly dependent on liability insurance and we seem to have greater and greater expectations from such insurance.

Cont'd.....

It is our sincere hope that within the next couple of years to-day's "jitters" will have disappeared and premium price levels will stabilize.

EVALUATION OF 1985 CONTRACT

During 1985 CDSPI sent us a large number of policies, taken out by individual dentists through their own local Brokers, for examination and comparison. When reviewing these files we compared not only premiums but also, more importantly, the coverages being offered. In all cases the CDSPI contract provided broader protection and, in most cases, the CDSPI premiums were very competitive.

For example, several weeks ago, we reviewed a contract, written through the Canadian General, for a dentist in Oshawa. His Comprehensive General Liability limit was \$1,000,000.00 and his premium was \$378.00 annual. Through CDSPI his premium would have been \$73.00.

Another example, in connection with Comprehensive General Liability premiums, is a dentist in Ottawa who is insured through the Phoenix Continental Group. His CGL limit is \$2,000,000.00 and the annual premium being charged was \$667.00. His premium, through CDSPI, in 1985, would have been \$80.00.

As can be readily seen, the above individuals are paying a far greater liability premium to their present carriers than they would have paid to the Guardian, through CDSPI. They would also have obtained much broader coverage through CDSPI because of the existing wording and the various "extras" built into your liability wording.

Our year-end figures indicate that the combined Loss Experience under the Office Contents, Business Interruption, and Comprehensive General Liability sections showed an improvement over 1984.

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There was a further deterioration, however, as far as the Malpractice loss ratio was concerned. The following factors, in our opinion, contributed to the adverse Malpractice results:

1. The Malpractice premiums, for all participants, were reduced in 1985.
2. There was a reduction in the number of Malpractice participants due to a large number of dentists, in the Province of Quebec, joining the ill-fated Gestas plan which, as predicted early last year, collapsed as of December 31st, 1985.
3. An increase in the number of reported claims.
4. An increase in the size of the reserves now being set-up by the Guardian because of increases in the size of recent awards.

Hopefully, because of higher rates and an anticipated increase in the number of participants in 1986, the Malpractice loss ratio will show a marked improvement.

1987 RENEWAL NEGOTIATIONS

Negotiations regarding the 1987 contract began on January 6, 1986. Representatives from our office and CDSPI met with the Guardian Insurance Company at that time to begin preliminary negotiations.

The meeting ended with good news and bad news.

GOOD NEWS - The Guardian will be providing a market for all coverages for 1987.

BAD NEWS - We will not be able to obtain any further rate reductions.

The same group of persons met again on February 6, 1986 to pursue negotiations in more detail. Many items were covered including proposed rates, changes in policy conditions and wording, change of Malpractice deductible clause, higher limits for additional Lease Expense coverage, a broadening of the Off Premises Heat, Power and Water Supply Extension endorsement, etc.

Further meetings on specific points, have been held over the past several months.

Because of existing conditions in the general insurance industry we have not approached any other markets as far as your 1987 contract is concerned. As was the case last year none of our existing markets are interested in writing Malpractice insurance or, for that matter, any other type of Professional Liability coverage. They also stated last year that they were not eager to quote on any of the

Cont'd.....

other three parts of your package (Office Contents, Business Interruption, and CGL) because of either the low premiums and/or broad coverage presently being offered.

As mentioned in the past we feel it is absolutely imperative that CDSPI continue to strive for continuity of a stable market at realistic (and reasonable) prices. Your long association with the Guardian Insurance Company has stood you in good stead as far as the 1987 renewal contract is concerned. The Guardian consider you to be a very valuable client and hope to be able to continue doing business with you for many years to come. They have stated their intention to do their utmost to make sure that your contract is always competitive in the marketplace from both a coverage and price standpoint.

1988 RENEWAL NEGOTIATIONS

We all realize that formal negotiations in connection with the 1988 Master contract will not begin until early January 1987.

Between now and then we will be constantly monitoring the Professional Liability situation. If and when new markets become available we will, after obtaining the approval of CDSPI, meet with these markets on an informal basis to determine whether or not they might be interested in quoting on your general insurance account.

CLAIMS SERVICE

It is our considered opinion that the Guardian Insurance Company, as well as the three independent adjusting firms representing them across Canada, is continuing to provide excellent claims service to the various participants. From time to time, of course, problems do arise. Where problems have arisen the Guardian Insurance Company has been only too willing to review the files and, in many cases, make additional payments where the situation warrants.

We have also noticed an improvement in the Guardian's response time to problem claims.

Over the past year representatives from our office have met with various senior officials from the three independent adjusting firms handling your claims. We have continued to impress upon them the importance of your account and the necessity to give each and every dentist prompt and fair attention. In some areas (Alberta and Quebec) it was necessary to have some of the poorer adjusters removed from the CDSPI account - a couple were actually fired. The independent adjusters, as well as the Guardian, are aware that we (F. Wallace Clancy & Son Ltd.) are continuing to monitor each claim on a daily basis.

The new Dental Professional Liability Insurance Claim Report form, prepared by CDSPI back in 1984, has helped bring about a noticable improvement in the Malpractice claims reporting area.

Effective May 1st, 1986 a Customer Satisfaction Index form has been introduced. A sample is attached. This form

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will help us to monitor what the various participants have to say about the claim service being offered by the Guardian and the independent adjusters. After a claim has been closed the Guardian will send a form letter (along with a postage paid return envelope) to the policy holder asking for his or her comments as to the claim service provided. All comments, whether positive or negative, will be passed along to CDSPI for their records



GUARDIAN INSURANCE

COMPANY OF CANADA

HEAD OFFICE: Guardian of Canada Tower, 181 University Avenue, Toronto, Ontario M5H 3M7
 CORRESPONDENCE: Post Office Box 4096, Station "A", Toronto, Ontario M5W 1N1
 TELEPHONE 863-4111 TELEEX 06-22412

RE: Canadian Dentists' Insurance Program - Account No. _____ - Guardian
 Insurance Company of Canada Master Policy No. 1043031- (_____)
 Claim Follow Up

Dear Dr.

Would you please help us?

A short while ago we made a final payment in settlement of your claim. We would like to know if you were entirely satisfied with the way the claim was handled.

The only chance we have to prove the value of our insurance is when claims are made upon our policies. You can help us give the best possible service on future claims by telling us frankly how we fared on this one.

We would appreciate it very much if you could take a few minutes to answer the following questions and return this letter in the enclosed stamped addressed envelope.

1. Who did you first report the claim to?
☐ CDSPI
☐ Guardian Insurance Co.
☐ A local adjuster
☐ Other. Please state _____
2. If CDSPI, did you receive all the information and assistance required?
☐ All - including a claim kit. Did you find it useful? Yes ☐
☐ Most No ☐
☐ Not much
3. How long after the incident did it take for you to report the claim to the adjuster?
☐ Same day
☐ One day
☐ Two days
☐ ____ days

4. After you reported your claim to the adjuster, how fast was his/her response to achieve settlement?
- ☐ Immediate
 - ☐ Acceptable
 - ☐ Slow
 - ☐ Not acceptable
5. After initial contact, was follow-up contact with the adjuster by:
- ☐ Phone
 - ☐ In person
 - ☐ In writing
6. Indicate, as appropriate, your assessment of the adjuster.
- ☐ Very helpful
 - ☐ Courteous
 - ☐ Knowledgeable of Canadian Dentists' Insurance Program
 - ☐ Did an acceptable job
 - ☐ Had to be pushed for results
 - ☐ Did not provide satisfactory service
 - ☐ Other. Please state _____
7. Length of time from date of claim to final settlement.
- ☐ Under one week
 - ☐ Under one month
 - ☐ One to three months
 - ☐ Over three months
8. Number of times the adjuster was in touch with you.
- ☐ By telephone
 - ☐ In person
9. Overall, were you satisfied with the service provided by the adjuster?
- Yes ☐ No ☐

If "NO", please provide details.

-3-

10. Malpractice Claims only:

Do you feel you and your claimant were treated fairly by the Insurance Company (through their adjuster)?

Yes ()

No ()

If "NO", please provide details.

11. Did you have to contact CDSPI a second time due to a perceived problem with the claim? Yes () No ()

If "YES", was CDSPI of assistance in solving the problem?

Yes ()

No ()

If "NO", please provide details.

Thank you for your cooperation.

Yours Truly,

Claims Department

c862-28a

1987 POLICY CHANGES

As a result of lengthy negotiations the following changes are now being proposed by the Guardian Insurance Company in connection with the 1987 contract.

A. Automatic Coverage Increase (Office Contents and Practice Interruption) -

In response to enquiries from participants, and in order to reduce administration costs, you will not be offering an automatic increase in coverage on July 1st, 1986. Instead, you will be changing the procedure to take effect on January 1st, 1987. This automatic increase will not be mandatory and each individual will have the option of rejecting the automatic coverage increase.

B. Off-Premises Extension (Practice Interruption) -

The existing wording in connection with Off-Premises Heat, Power and Water Supply is to be replaced by the following wording which will give all participants broader coverage at no increase in rates - "Notwithstanding any of the perils excluded under SECTION II of this Policy, the insurance provided by SECTION II - PRACTICE INTERRUPTION INSURANCE is hereby extended to include loss, resulting from damage to or destruction of any property located away from the premises occupied exclusively by the Insured, when such damage or destruction is caused by the perils insured against".

C. Additional Lease Expense (Office Contents) -

In the 1986 contract the Office Contents section was extended to provide additional lease expense coverage, up to an amount of \$5,000.00, at no charge. A participant could not purchase additional coverage. In 1987 a participant will be able to purchase additional coverage, under this section of the policy, up to a maximum of \$10,000.00 extra.

D. Pollution Exclusion Clause (Comprehensive General Liability) -

The Guardian have advised that it will be necessary to insert a Pollution Exclusion Clause into the 1987 policy wording. In actual fact this clause was to be

Cont'd.....

D. Pollution Exclusion Clause (Comprehensive General Liability) - continued:

written into the 1986 contract (due to last minute insistence by the reinsurance companies) but the Guardian Insurance Company, on the strong urgings of CDSPI and our office, was successful in getting the reinsurers to hold off until January 1st, 1987.

E. Wrongful Dismissal (Comprehensive General Liability) -

The Guardian Insurance Company had wanted to eliminate Wrongful Dismissal coverage from the Comprehensive General Liability section of your contract. They have now agreed, however, to leave this coverage in the 1987 policy wording.

F. Pre-judgement Interest (Comprehensive General Liability and Malpractice) -

As of January 1st, 1987 the amount of any pre-judgement interest paid will be included in the Limit of Liability shown on an individual's Memorandum of Insurance and will not be in addition to the Limit of Liability shown on the Memorandum of Insurance. However all interest accruing after entry of judgement and up to the date of payment by the Insurer of it's share of any judgement will be paid in addition to the Limit of Liability shown on the Memorandum of Insurance.

G. Intentional Acts (Comprehensive General Liability) -

At the present time your Comprehensive General Liability coverage does not apply to claims arising out of bodily injury caused intentionally by or at the direction of an executive officer of the Insured, unless committed for the purpose of protecting persons or property. As of January 1st, 1987 the section will be amended to read as follows - "this insurance does not apply to claims arising out of bodily injury caused intentionally by or at the direction of an executive officer of the Insured, but this exclusion does not apply with respect to use of reasonable force for the purpose of protecting persons or property".

H. Territory Definition (Malpractice) -

The "Territory" definition will be amended to read as follows - "this insurance applies only to acts or

Cont'd....

H. Territory Definition (Malpractice) - continued:

ommissions committed by an Insured in Canada, except that where an Insured is acting under the auspices of the Canadian Armed Forces, this insurance also applies to acts or ommissions wherever committed; which arise out of the usual or ordinary duties of the Insured as such, provided, however, that there shall be no liability under this policy for claims arising therefrom unless all actions to recover are brought in Canada and not elsewhere". In other words the only change is in limiting the geographic area where a suit could be brought, to that of Canada.

I. Five Year Extension (Malpractice) -

As far as the Guardian Insurance Company is concerned they are certainly prepared to continue to leave the five year extension as is for 1987. The Guardian, however, has pointed out that their reinsurers may insist upon changing this to a two-year extension before agreeing to go on risk as of January 1st, 1987. Hopefully, however, the reinsurers will agree to leave this section of your contract unchanged.

Should it be necessary to change to a two-year extension it will still be possible for individuals and/or their estates to continue purchasing coverage, at a nominal fee, on an annual basis for however long they desire.

J. Limits - Partners Each Claim Limit (Malpractice) -

The following section will be added to the Malpractice wording - "If a claim arises against an Insured based solely on the laws of partnership and if more then one memorandum provides coverage, the amount payable with respect to that claim under all the said memorandums shall not exceed the highest per claim limit shown in any one of the memorandums". This clause is identical to that which is already printed on the Malpractice memorandums which you send to each participant.

K. Notice of Claim (Malpractice) -

In order to avoid any misunderstandings and to clear up a "grey" area in your contract the following section will be added to the Malpractice portion of your policy -

Cont'd.....

K. Notice of Claim (Malpractice) - continued:

"If the policy period ends on a Saturday, Sunday or Statutory Holiday, then any claim presented to the Insurer or their Adjusters on the business day immediately following such Saturday, Sunday or Statutory Holiday, will be deemed to have been presented to the Insurers during the policy period if such claim had been presented to the Insured on such Saturday, Sunday or Statutory Holiday".

L. Notice of Claim (Comprehensive General Liability and Malpractice) -

The word "suit" is being eliminated from these sections of the policy. The Guardian has had it brought to their attention, by their solicitors, that there could be certain difficulties in defending some actions because of the existing policy terminology. Therefore the lawyers have proposed this change in order to assist in future defence.

GUARDIAN'S 1987 RENEWAL QUOTATIONS

The actual renewal quotations are contained on a separate page. At this time we are giving you a brief summary of the renewal quotations which are as follows:

OFFICE CONTENTS -

The premiums will be increased by 5% in 1987.

VALUABLE PAPERS -

Rates unchanged for 1987.

ACCOUNTS RECEIVABLE -

Rates unchanged for 1987.

MONEY SECURITIES AND PRECIOUS METALS -

Rates unchanged for 1987.

RENTAL VALUE -

Rates unchanged for 1987.

EXTRA EXPENSE -

Rates unchanged for 1987.

DEPOSITOR'S FORGERY -

Rates unchanged for 1987.

ADDITIONAL LEASE EXPENSE COVERAGE -

An individual can now purchase additional coverage (over and above the basic limit of \$5,000.00) up to a maximum of \$10,000.00 extra as per the rates shown on the attached schedule.

Cont'd.....

PRACTICE INTERRUPTION -

Rates unchanged for 1987.

COMPREHENSIVE GENERAL LIABILITY -

The premiums for the various Limits of Liability offered have all increased - see rate schedule attached. As can be readily seen the pricing for the \$1,000,000.00 layer is out of step with what the market considers appropriate for the \$2,000,000.00 and \$3,000,000.00 layers. The bulk of the participants are only purchasing Comprehensive General Liability Limits of \$1,000,000.00 inclusive. The Guardian has been advised by their reinsurers that they (the reinsurers) need more premium for the \$2,000,000.00 and \$3,000,000.00 levels in order to continue offering the coverage.

The Guardian feels that if the majority of the participants increased their Comprehensive General Liability Limits to either \$2,000,000.00 inclusive or \$3,000,000.00 inclusive then the premiums, for these levels, would be reduced between 10 and 15 percent.

As mentioned earlier in this report we still feel that the premiums for all three levels (particularly \$1,000,000.00 inclusive level) are still competitive particularly when you consider the various "extras" built into the policy wording.

MALPRACTICE LIABILITY (AUXILIARIES) -

The premium for auxiliaries will remain unchange in 1987.

MALPRACTICE (EXCLUDING AUXILIARIES) -

After several meetings in early 1986 the Guardian

Cont'd...

MALPRACTICE (EXCLUDING AUXILIARIES) - continued:

advised us, based on actuarial figures, that the gross premium per dentist, for a limit of \$1,000,000.00 inclusive, would have to be increased from \$439.00 to \$585.00. Further negotiations have reduced this increase down to \$575.00.

The Guardian originally wanted the gross premium per dentist, for a limit of \$2,000,000.00, increased from \$483.00 to \$661.00. This has now been revised downwards to \$653.00.

As you are aware your Malpractice policy now contains a \$2,000.00 Repeater deductible. Quite frankly, the Guardian does not feel that the Repeater deductible has had any noticable effect as far as improving your overall loss experience is concerned. The Guardian is prepared to drop the Repeater deductible from the 1987 contract and leave the above renewal quotations unchanged. If, however, you feel that the Repeater deductible still serves a useful purpose, from a loss prevention standpoint, you might wish to leave it in your contract. The final decision will be left to you.

The Guardian Insurance Company have also submitted alternate Malpractice quotations for your consideration. Should you wish to switch to a straight \$500.00 deductible on each loss then the revised gross premium per dentist would be as follows:

\$1,000,000.00 inclusive	=	\$ 557.00 (gross)
\$2,000,000.00 inclusive	=	\$ 635.00 (gross)

Should you wish to insert a straight deductible of \$1,000.00 on each claim then the revised gross premium per dentist would be as follows:

Cont'd.....

\$1,000,000.00 = \$ 538.00 (gross)

\$2,000,000.00 = \$ 616.00 (gross)

Because of the small premium saving involved we do not necessarily think that you should go to a straight deductible at this point in time unless, of course, you feel that such a straight deductible on each and every loss would serve a useful purpose from a loss prevention standpoint.

OPTIONAL COVERAGE FOR FUTURE DISCUSSION

Once again, during our recent renewal negotiations with the Guardian in connection with your 1987 contract, we discussed the possibility of including Umbrella Liability as an extra option in your contract.

As was the case last year we asked the Guardian Insurance Company to consider providing a market whereby a dentist could purchase Umbrella Liability insurance to cover his or her practice and personal pursuits (exluding Malpractice). As was the case last year the Guardian had a difficult time in getting any one of their reinsurers to quote on this coverage particularly in view of the fact that they (the Guardian) are asking for a 1987 quote in early 1986.

Nonetheless the Guardian were successful in arranging a tentative quote as follows:

- A. \$3,000,000.00 Excess of underlying limit - \$ 153.00
per dentist net.
- B. \$4,000,000.00 Excess of underlying limit - \$ 166.00
per dentist net.
- C. \$5,000,000.00 Excess of underlying limit - \$ 175.00
per dentist net.

The above tentative quotations would be subject to the following terms:

Individual applications for each dentist

Minimum underlying limits of \$1,000,000.00 inclusive on CGL, Personal Liability, and Automobile

Excluding Malpractice

Full care, custody, and control exclusion.

Cont'd.....

Following form on automobile.

The Guardian have also advised that the above quotes are subject to a minimum retained premium of \$50,000.00 which is to be due and payable on January 1st, 1987. In other words, in order to avoid a premium being levied against CDSPI, it would be necessary for approximately 350 dentists to participate in this option.

It is our understanding that you will be having further discussions as to whether or not you would like Umbrella Liability coverage offered as an extra option in connection with the 1987 contract.

RATE SCHEDULE

1987 General Insurance

Renewal Comparisons

	<u>Current Rates</u> <u>Guardian</u>		<u>Proposed Rates</u> <u>Guardian</u>	
	<u>Net</u>	<u>Gross</u>	<u>Net</u>	<u>Gross</u>
Office Contents	per provincial schedules		5% increase - see new provincial schedules attached.	
Business Interruption per \$1,000)	2.05	2.36	2.05	2.36
C G L				
(per \$1,000,000)	63.55	73.08	69.00	79.00
(per \$2,000,000)	69.57	80.00	150.00	173.00
(per \$3,000,000)	96.00	110.00	188.00	216.00
Malpractice				
(per \$1,000,000)	381.65	439.00	500.00	575.00
(per \$2,000,000)	419.91	483.00	568.00	653.00
Auxiliaries				
(per \$500,000)	12.03	13.84	12.03	13.84
(per \$1,000,000)	16.87	19.40	16.87	19.40

* Please note - (Net + 15% = Gross)
The gross premiums proposed for 1987 for C.G.L. and
Malpractice (excluding Auxiliaries) have been rounded
to the nearest dollar.

Annual Premium rates for Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia

\$500 DEDUCTIBLE

\$250 DEDUCTIBLE

	PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)				UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)				PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)				UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)			
	FIRE RESISTIVE MASONRY		FRAME		FIRE RESISTIVE MASONRY		ALL OTHER UNPROTECTED		FIRE RESISTIVE MASONRY		FRAME		FIRE RESISTIVE MASONRY		ALL OTHER UNPROTECTED	
COVERAGE AMOUNT																
\$10,000	62	73	86	68	80	91	71	83	97	77	89	103				
\$15,000	74	89	103	81	95	117	84	100	116	91	108	133				
\$20,000	87	103	122	94	110	146	98	116	138	107	125	163				
\$25,000	100	121	148	111	131	173	112	136	165	124	148	195				
\$30,000	107	133	164	122	147	197	121	150	185	138	164	220				
\$35,000	117	146	183	133	160	220	131	163	204	150	180	247				
\$40,000	124	157	199	143	172	245	140	175	224	161	194	272				
\$45,000	133	169	217	154	187	263	150	190	243	173	210	294				
\$50,000	142	182	235	167	202	281	159	203	262	186	226	314				
\$55,000	148	190	247	173	214	297	167	213	275	194	239	331				
\$60,000	153	198	257	182	225	311	173	223	287	204	252	347				
\$65,000	161	207	268	190	236	325	181	231	301	212	264	362				
\$70,000	168	215	280	198	248	340	187	242	313	222	278	379				
\$75,000	173	225	292	206	259	354	194	251	327	230	290	394				
\$80,000	180	234	303	214	270	368	201	261	339	239	303	412				
\$85,000	186	242	316	222	283	383	208	270	352	248	316	427				
\$90,000	193	251	327	230	295	396	216	279	365	257	329	443				
\$95,000	199	259	338	238	306	412	223	290	378	267	341	460				
\$100,000	205	268	351	245	318	426	230	300	390	275	355	476				
FOR EACH ADDITIONAL \$5,000	5	6	9	6	10	11	6	7	10	7	11	13				

Additional Coverages:

\$500.00 DED.
\$250.00 DED.

1. Valuable papers & records; basic limit \$5,000; (units of \$1,000) \$2.05 \$2.05
2. Extra expense; basic limit \$5,000; (units of \$1,000) \$1.84 \$1.84
3. Money & Securities; basic limit \$2,000; (Units of \$1,000 to a maximum of \$8,000 extra) \$21.63 \$23.70
4. Depositors Forgery; basic limit \$5,000; NO INCREASE AVAILABLE
5. Accounts receivable; basic limit \$10,000; (Units of \$1,000) \$1.84 \$1.84
6. Rental value; basic limit \$5,000 (units of \$1,000) \$2.05 \$2.05
7. Additional lease expense; basic limit \$5,000; (Units of \$1,000 to a maximum of \$10,000 extra) \$2.00 \$2.00

Section II - "ALL RISKS" PRACTICE INTERRUPTION INSURANCE
Units of \$1,000: (No deductible applies) \$2.05

Ann Premium rates for Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia

\$500 DEDUCTIBLE

\$250 DEDUCTIBLE

COVERAGE AMOUNT	PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)			UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)			PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)			UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)		
	FIRE RESISTIVE	MASONRY	FRAME	FIRE RESISTIVE	MASONRY	ALL OTHER	FIRE RESISTIVE	MASONRY	FRAME	FIRE RESISTIVE	MASONRY	ALL OTHER
\$10,000	71	84	99	78	92	105	82	96	111	86	103	119
\$15,000	85	102	119	93	109	134	97	114	133	105	124	153
\$20,000	100	119	141	108	127	168	112	133	159	123	144	188
\$25,000	114	140	170	128	151	200	129	156	190	143	170	225
\$30,000	123	153	189	141	169	227	139	172	213	159	189	253
\$35,000	134	168	210	153	184	253	150	188	234	172	207	284
\$40,000	143	181	229	165	197	281	161	202	257	185	223	313
\$45,000	153	194	250	177	215	302	172	218	279	200	242	338
\$50,000	163	209	270	192	232	323	183	233	301	214	259	361
\$55,000	170	218	284	200	246	341	192	245	316	224	275	380
\$60,000	176	228	296	209	258	358	200	256	330	234	290	399
\$65,000	185	238	309	218	272	374	208	266	347	244	303	417
\$70,000	193	248	322	228	286	391	215	278	360	255	319	436
\$75,000	200	258	336	237	298	407	223	289	376	265	334	454
\$80,000	207	269	349	246	311	423	231	300	390	275	349	474
\$85,000	214	278	363	255	326	440	239	311	405	286	363	491
\$90,000	222	289	376	265	339	456	249	321	420	295	378	509
\$95,000	229	298	389	274	352	474	256	334	435	307	392	529
\$100,000	235	308	403	281	365	490	265	345	448	316	408	547
FOR EACH ADDITIONAL \$5,000	6	7	11	7	12	13	7	8	12	8	13	15

Additional Coverages:

\$500.00 \$250.00
DED. RED.

1. Valuable papers & records; basic limit \$5,000; (units of \$1,000)
 2. Extra expenses; basic limit \$5,000; (units of \$1,000)
 3. Money & Securities; basic limit \$2,000; (units of \$1,000 to a maximum of \$8,000 extra)
 4. Depositors Forgery; basic limit \$5,000;
 5. Accounts receivable; basic limit \$10,000; (units of \$1,000)
 6. Rental value; basic limit \$5,000 (units of \$1,000)
 7. Additional lease expenses; basic limit \$5,000; (units of \$1,000 to a maximum of \$10,000 extra)
- NO INCREASE AVAILABLE
- \$2.36 \$2.36
\$2.12 \$2.12
\$2.36 \$2.36
\$2.30 \$2.30

Section II - "ALL RISKS" PRACTICE INTERRUPTION INSURANCE
Units of \$1,000; (No deductible applies) \$2.36

Annual Premium rates for Quebec, Nova Scotia, New Brunswick, P.E.I., Newfoundland, Yukon, and North West Territories

\$500 DEDUCTIBLE

\$250 DEDUCTIBLE

COVERAGE AMOUNT	PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)			UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)			PROTECTED BUILDINGS (within 1,000 feet of fire hydrant)			UNPROTECTED BUILDINGS (not within 1,000 feet of fire hydrant)		
	FIRE RESISTIVE	MASONRY	FRAME	FIRE RESISTIVE	ALL OTHER UNPROTECTED	FIRE RESISTIVE	MASONRY	FRAME	FIRE RESISTIVE	MASONRY	FRAME	FIRE RESISTIVE
\$10,000	71	86	97	76	99	80	97	109	84	111		
\$15,000	69	110	130	103	132	100	125	146	118	149		
\$20,000	108	135	161	133	165	121	152	182	150	186		
\$25,000	128	161	194	166	201	143	182	217	184	225		
\$30,000	142	182	220	191	228	160	203	247	214	256		
\$35,000	157	201	246	215	254	176	225	274	240	284		
\$40,000	172	220	269	239	279	192	247	302	260	312		
\$45,000	186	240	294	261	303	208	268	328	292	339		
\$50,000	200	258	317	284	328	224	289	354	318	366		
\$55,000	210	276	336	302	351	236	309	376	338	390		
\$60,000	222	294	357	321	372	247	328	398	358	415		
\$65,000	232	311	377	340	394	259	347	421	379	439		
\$70,000	242	328	396	358	416	271	366	443	399	465		
\$75,000	253	346	417	377	437	283	385	466	421	488		
\$80,000	263	362	437	394	460	294	405	488	441	513		
\$85,000	274	380	459	413	482	307	424	510	461	537		
\$90,000	285	396	478	432	503	319	443	533	482	561		
\$95,000	295	415	499	451	526	331	464	555	502	586		
\$100,000	305	432	520	470	548	341	482	579	523	610		
FOR EACH ADDITIONAL \$5,000	8	13	16	14	18	9	16	17	16	20		

Additional Coverages:

\$500.00 DED. \$250.00 DED.

1. Valuable papers & records; basic limit \$5,000; (units of \$1,000) \$2.05
2. Extra expenses; basic limit \$5,000; (units of \$1,000) \$2.05
3. Money & Securities; basic limit \$2,000; (units of \$1,000 to a maximum of \$8,000 extra) \$1.84
4. Depositors Forgery; basic limit \$5,000; NO INCREASE AVAILABLE
5. Accounts receivable; basic limit \$10,000; (units of \$1,000) \$1.84
6. Rental value; basic limit \$5,000 (units of \$1,000) \$2.05
7. Additional lease expense; basic limit \$5,000; (units of \$1,000 to a maximum of \$10,000 extra) \$2.00

Section II - "ALL RISKS" PRACTICE INTERRUPTION INSURANCE
Units of \$1,000; (No deductible applies) \$2.05

SECT - ALL RISKS OFFICE CONTENTS (GROSS 1987)

Annual Premium rates for Quebec, Nova Scotia, New Brunswick, P.E.I., Newfoundland, Yukon, and North West Territories

\$500 DEDUCTIBLE

\$250 DEDUCTIBLE

PROTECTED BUILDINGS
(within 1,000
feet of fire hydrant)

UNPROTECTED BUILDINGS
(not within 1,000
feet of fire hydrant)

UNPROTECTED BUILDINGS
(not within 1,000
feet of fire hydrant)

COVERAGE AMOUNT	FIRE RESISTIVE			FIRE RESISTIVE			FIRE RESISTIVE			FIRE RESISTIVE			FIRE RESISTIVE		
	MASONRY	FRAME	ALL OTHER UNPROTECTED	MASONRY	FRAME	ALL OTHER UNPROTECTED	MASONRY	FRAME	ALL OTHER UNPROTECTED	MASONRY	FRAME	ALL OTHER UNPROTECTED	MASONRY	FRAME	ALL OTHER UNPROTECTED
\$10,000	\$82	\$99	\$111	\$87	\$119	\$152	\$113	\$92	\$116	\$144	\$174	\$209	\$212	\$258	\$294
\$15,000	\$103	\$126	\$149	\$119	\$153	\$190	\$152	\$140	\$174	\$209	\$250	\$284	\$315	\$359	\$421
\$20,000	\$124	\$155	\$185	\$153	\$191	\$231	\$165	\$140	\$174	\$209	\$250	\$284	\$315	\$359	\$421
\$25,000	\$147	\$185	\$223	\$191	\$209	\$263	\$184	\$165	\$209	\$250	\$284	\$315	\$359	\$421	\$478
\$30,000	\$164	\$209	\$253	\$219	\$247	\$292	\$203	\$184	\$233	\$263	\$294	\$327	\$366	\$407	\$448
\$35,000	\$181	\$231	\$282	\$247	\$275	\$321	\$221	\$203	\$258	\$284	\$315	\$348	\$377	\$407	\$448
\$40,000	\$197	\$253	\$310	\$275	\$300	\$349	\$239	\$221	\$284	\$315	\$348	\$377	\$390	\$421	\$458
\$45,000	\$214	\$276	\$338	\$300	\$327	\$377	\$257	\$239	\$308	\$333	\$365	\$390	\$407	\$421	\$458
\$50,000	\$230	\$297	\$364	\$327	\$348	\$403	\$272	\$257	\$333	\$365	\$390	\$407	\$421	\$458	\$491
\$55,000	\$242	\$317	\$386	\$348	\$370	\$427	\$285	\$272	\$355	\$389	\$412	\$433	\$458	\$484	\$505
\$60,000	\$255	\$338	\$411	\$370	\$391	\$453	\$298	\$285	\$377	\$412	\$433	\$458	\$484	\$505	\$534
\$65,000	\$267	\$358	\$434	\$391	\$412	\$479	\$312	\$298	\$399	\$433	\$458	\$484	\$505	\$534	\$562
\$70,000	\$278	\$377	\$456	\$412	\$434	\$503	\$326	\$312	\$421	\$458	\$484	\$505	\$534	\$562	\$590
\$75,000	\$291	\$398	\$480	\$434	\$454	\$529	\$338	\$326	\$443	\$484	\$505	\$534	\$562	\$590	\$617
\$80,000	\$302	\$417	\$503	\$454	\$475	\$554	\$353	\$338	\$466	\$505	\$534	\$562	\$590	\$617	\$645
\$85,000	\$315	\$437	\$528	\$475	\$497	\$579	\$366	\$353	\$487	\$528	\$554	\$587	\$613	\$645	\$674
\$90,000	\$328	\$456	\$550	\$497	\$519	\$605	\$380	\$366	\$509	\$533	\$562	\$587	\$613	\$645	\$674
\$95,000	\$339	\$478	\$573	\$519	\$541	\$630	\$393	\$380	\$533	\$562	\$587	\$613	\$638	\$674	\$701
\$100,000	\$351	\$497	\$597	\$541	\$630	\$393	\$554	\$393	\$554	\$587	\$613	\$638	\$666	\$701	\$728
FOR EACH \$5,000	\$9	\$15	\$18	\$16	\$21	\$11	\$18	\$11	\$18	\$20	\$19	\$23	\$20	\$23	\$26
Additional Coverages:															
DED. \$500.00 DED. \$250.00															

1. Valuable papers & records; basic limit \$5,000; (units of \$1,000) \$2.36
2. Extra expense; basic limit \$5,000; (units of \$1,000) \$2.12
3. Money & Securities; basic limit \$2,000; (units of \$1,000 to a maximum of \$8,000 extra) \$24.88
4. Depositors Forgery; basic limit \$5,000; \$27.26
5. Accounts receivable; basic limit \$10,000; (units of \$1,000) \$2.12
6. Rental value; basic limit \$5,000 (units of \$1,000) \$2.36
7. Additional lease expense; basic limit \$5,000; (units of \$1,000 to a maximum of \$10,000 extra) \$2.30

NO INCREASE AVAILABLE

Section II - "ALL RISKS" PRACTICE INTERRUPTION INSURANCE
Units of \$1,000: (No deductible applies) \$2.36

RECOMMENDATION FOR 1987 CONTRACT

Because of existing market conditions the Guardian has stated the following - "In prior years our quotations have been unconditional. For 1987 however our quote is conditional on there being no changes in our reinsurance treaty wordings, or terms in 1987. Our reinsurance treaties for 1987 will be negotiated during the period October to December 1986. In the event that they are changed we reserve the right to change the terms of these quotes.

In addition, should there be statutory changes imposed upon us then we reserve the right to amend our quotes to reflect these changes".

On January 1st, 1984 we were fortunate enough to be selected as Broker of Record for CDSPI. At that time we alluded to the impending "market crunch" which we felt would take place within the next couple of years. We stated that in our seventy-five years of operation (now seventy-eight) we had always taken pride in representing Companies that, in our opinion, offered our policy-holders the following:

- A. Stable and consistent underwriting.
- B. Stable and competitive pricing.
- C. The willingness to continue to provide coverage on accounts which have had an adverse loss experience.
- D. Prompt and fair claims settlements.

It is our considered opinion that the Guardian has in the past and will continue in the future to meet our standards and yours.

Cont'd.....

In spite of present problems in the insurance industry we do not feel that the Guardian Insurance Company has tried to take advantage of existing market conditions and that they have done their very best to keep the premium and rate increases to a minimum.

At this time we feel that the Board of CDSPI should consider approval of all of the proposed changes relating to rates, premiums, and wording. At the same time we feel that any changes of any kind necessitated by market conditions outside of the control of the Guardian Insurance Company must be submitted to the Board of CDSPI, as soon as the changes become known, for final consideration and approval.

Notwithstanding the above, and as a result of discussions with senior Guardian officials, we feel reasonably confident that the Guardian Insurance Company will be able, after final negotiations with their reinsurers, to honor all of the proposed 1987 policy changes including rates.

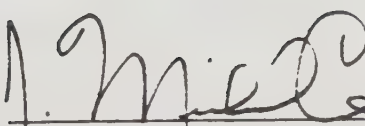
We are also aware that the above conditions outlined by the Guardian will have an effect on your administration procedures from a time standpoint. The Guardian Insurance Company will be meeting with CDSPI representatives within the next couple of weeks in order to determine what changes in procedures might be necessary as a result of market conditions in the Fall of 1986.

Our office continues to appreciate the opportunity of working with CDSPI to provide what we feel is a "top-notch" insurance program. We sincerely hope that the information

Cont'd.....

outlined in this report will be of assistance in your review of insurance placements for CDSPI. Our office would welcome the opportunity of reviewing any point or detail that you might commit to us for an opinion.


CHUCK WILLS


MIKE CLANCY

CANADIAN DENTISTS' INSURANCE PROGRAM

DISTRIBUTION OF LIFE SURPLUS - 1986

Kenneth T. Ransby

February 23, 1986

CANADIAN DENTISTS' INSURANCE PROGRAM

DISTRIBUTION OF LIFE SURPLUS

I. INTRODUCTION

In a report dated August 29, 1985, we recommended that the Life account surplus under the Canadian Dentists' Insurance Program be distributed to Plan participants as follows:

- (a) Commencing in 1985, in each year determine the amount of interest earned (I) on the Life surplus for the year, and any new experience gains (E) which increase the Life account.
- (b) Determine the premium rate subsidies (S) for the year.
- (c) Determine the amount (R) required to increase the special contingency reserve (now \$1,000,000, or 50% of the net experience-rated premium) to 50% of the then annualized net experience-rated premium.
- (d) The surplus available for distribution in the ensuing year would then be equal to:

$$\begin{array}{l} \text{Distributable} = I + E - S - R \\ \text{Surplus} \end{array}$$

- (e) The total "distributable surplus" thus determined would be reduced by any transfers from surplus authorized by the CDA to increase the Rate Stabilization Reserve or to meet any new premium subsidies under the Plan.
- (f) Allocations would be made to the individual Plan participants, based upon a method adopted by the CDA.

On October 5, 1985, the Board of Directors of CDSPI approved this distribution formula, and approved the premium credit method of distribution.

The purpose of this report is to determine the amount of surplus which could be distributed as a premium credit and applied to invoices for premiums due January 1, 1987.

II. DETERMINATION OF DISTRIBUTABLE SURPLUS

We received the 1985 financial statements from Imperial Life approximately two weeks ago. For this reason, the actuarial audit of the reports by TPF&C is still in progress. The preliminary checks which we have made to date, however, indicate that the financial report is sufficiently accurate for purposes of determining the distributable surplus.

By utilizing the formula stated in the previous section, the distributable surplus arising in 1985 was determined as follows:

- (a) During 1985, there was \$760,453 in total interest earned on the Life surplus and actuarial liabilities. Of this total, we determined that approximately \$478,000 was earned on the Life surplus.

Thus, I = \$478,000

In addition, the new experience gains (E) which increased the surplus account were determined as follows:

E = Surplus at end of year
- Surplus at beginning of year
- Interest earned on surplus in year
+ Premium subsidies during year

E = \$5,706,000 - \$4,994,000 - \$478,000 + \$516,000

Thus, E = \$750,000

- (b) The premium rate subsidies (S) for the year were approximately \$516,000. Although discussions are being held with Imperial Life concerning the calculation of the non-smoker premium rate subsidy, this amount was accepted for purposes of the determination of the surplus distribution.

Thus, S = \$516,000

- (c) As at the end of 1985, the annualized net experience-rated premium was approximately \$2,108,000. The new level of the special contingency reserve is then 50% for this amount, or approximately \$1,054,000. The increase (R) in this reserve from the former \$1,000,000 level of this reserve, is then \$54,000.

Thus, R = \$54,000

- (d) The surplus available for distribution is then equal to:

$$\begin{aligned} \text{Distributable} &= I + E - S - R \\ \text{Surplus} &= \$478,000 + \$750,000 - \$516,000 - \$54,000 \end{aligned}$$

or, Distributable = \$658,000
Surplus

- (e) There were no other transfers from surplus authorized by the CDA during 1985 to increase the Rate Stabilization Reserve or to meet any new premium subsidies under the Plan.
- (f) It is our understanding that the Board of Directors of CDSPI has decided to recommend the percentage premium credit method of surplus distribution to the Board of Directors of the CDA.

In our opinion, the most administratively practical method of implementing the premium credit would be to establish a premium credit for the Life plan participants in 1987, based on the insurance in-force as at the end of 1986.

During 1985, the gross life premium -- before premium subsidies -- increased by approximately 10%. Assuming that the increase in gross premium during 1986 will again be 10%, the premium credit was determined as follows:

(i)	Gross Premium at Dec. 31, 1985	= \$2,965,000
(ii)	Estimated Gross Premium at Dec. 31, 1986	= 1.10 x 2,965,000 = 3,262,000
(iii)	Estimated Subsidies in 1987	= \$500,000
(iv)	Estimated Billed Premium, 1987	= (ii) - (iii) = \$2,762,000
(v)	Distributable Surplus	= \$658,000
(vi)	Percentage Premium Credit	
	$= \frac{(v)}{(iv)} \times 100\%$	= 23.8%

In other words, when the Life premium invoices for the 1987 plan year are issued in mid-November of 1986, we recommend that a premium credit equal to 23.8% of the gross Life premium otherwise due, be shown on each invoice.

II. SUMMARY

On October 5, 1985, the Board of Directors of CDSPI approved the proposed Life surplus distribution formula, and approved the premium credit method of surplus distribution.

We determined that approximately \$658,000 of the Life surplus should be distributed in 1987. This amount of surplus could be distributed by including in the invoices issued in mid-November of 1986, a premium credit equal to 23.8% of the gross Life premium otherwise due.

CDA RSP GROWTH

APPENDIX E

MONTH: MARCH 1986PLAN YEAR 1986

	\$ Current Month	\$ Year-to-Date 1986	\$ Year-to-Date 1985	% Increase (Decrease)
NEW ACCOUNTS	35	35	7	400%
<u>CONTRIBUTIONS:</u>				
Fixed Income	269,571.95	269,571.95	13,434.16	1906%
Common Stock	264,511.96	264,511.96	41,134.50	543%
Money Market	225,131.08	225,131.08	75,436.83	198%
Balanced Fund	215,042.62	215,042.62	5,475.72	3827%
Sub-Total	974,257.61	974,257.61	135,481.21	619%
Guaranteed Fund				
1-Year	23,781.77	23,781.77	985.75	--
2-Year	2,471.96	2,471.96	--	--
3-Year	17,818.10	17,818.10	--	--
4-Year	--	--	--	--
5-Year	23,789.33	23,789.33	--	--
Sub-Total	67,861.16	67,861.16	985.75	--
TOTAL CONTRIBUTIONS (includes Transfers-in)	1,042,118.77	1,042,118.77	136,466.96	663%
<u>TRANSFERS-IN:</u>				
Number of Transfers	97	97	18	438%
Amount \$	969,672.96	969,672.96	103,200.27	839%
NET CONTRIBUTIONS	72,445.81	72,445.81	33,266.69	117%
<u>DE-REGISTRATIONS:</u>				
Number of Accounts	12	12	10	20%
Amount \$	287,698.63	287,698.63	238,586.53	20%
<u>NET GAIN (LOSS):</u>				
Number of Accounts		23	(3)	
Amount \$	754,420.14	754,420.14	(101,133.82)	
TOTAL # OF ACCOUNTS		1,788	1,410	27%
<u>Comments:</u>				

RSP STATISTICS - 1985 TAX YEAR

ACCOUNTS	MAR. 1985	APR. 1985	MAY 1985	JUNE 1985	JULY 1985	AUG. 1985	SEPT. 1985	OCT. 1985	NOV. 1985	DEC. 1985	JAN. 1986	FEB. 1986	TOTAL
CONTRIBUTIONS:	7	14	6	10	7	5	16	6	25	22	43	292	453
Net Income	13,434.16	26,672.56	28,680.86	33,264.53	43,937.80	59,823.63	106,023.59	88,318.86	95,477.27	116,424.60	225,355.03	715,369.54	1,532,002.43
New Stock	41,134.50	34,635.95	30,728.48	46,117.34	46,179.36	49,240.97	63,370.46	16,104.03	80,218.81	150,878.33	236,467.78	1,180,017.95	1,975,093.96
Buy Market	75,436.83	68,028.51	48,260.87	29,521.93	23,937.50	168,529.45	98,272.40	117,246.04	159,904.32	122,681.26	127,337.78	477,880.42	1,517,057.31
Unrec'd Fund	5,475.72	13,037.75	2,731.70	7,370.48	19,099.97	8,085.26	74,827.84	34,038.73	36,670.12	28,137.58	90,998.27	753,855.68	1,074,409.11
Total	135,481.21	142,394.77	110,421.91	116,274.28	133,174.63	285,679.31	342,494.29	255,727.66	372,270.52	418,141.77	680,178.86	3,127,123.60	6,119,362.81
UNRECEIVED FUND													
Year	985.75	17,784.59	340.00	340.00	10,089.48	340.00	15,045.80	3,840.00	340.00	11,375.00	10,634.00	173,571.50	244,666.12
Year		13,812.74	11,197.80	8,578.72	750.00	6,676.77		750.00		4,000.00	24,752.57	41,864.09	44,364.09
Year		41,860.72	1,309.99	22,107.28	11,000.00				6,500.00	21,142.98	11,946.58	59,624.00	175,491.55
Year	985.75	73,458.05	12,847.79	31,026.00	21,839.48	7,016.77	15,045.80	4,590.00	6,840.00	36,517.98	49,833.15	330,359.59	590,360.36
Total	136,466.96	215,852.82	123,269.70	147,300.28	155,014.11	292,696.08	357,540.09	260,317.66	379,110.52	454,659.75	730,012.01	3,457,483.19	6,709,723.17
of Transfers-In	18	26	14	21	19	10	26	17	29	41	36	43	300
Unrec'd in \$	103,200.27	186,222.62	56,556.10	65,808.97	71,883.76	179,767.16	267,193.87	193,556.77	192,302.27	266,118.48	295,850.22	478,393.26	2,356,853.75
of Dereg's	10	17	8	4	7	5	3	5	5	5	8	14	92
POSITION OF DERECS													
Net RSP's - G.I.C.	24,859.57	71,798.51											43,401.06
- S.D.	30,789.35	151,586.36											104,028.61
- Other	83,924.38	79,591.79											82,636.33
Total	139,573.30	302,976.66											140,059.44
Withdrawals	55,085.76	209,387.19											439,115.34
Excess Contrib.	5,000.00	43,900.00											16,300.00
Net Benefits	38,927.47												3,759.00
Total	238,986.53	556,263.85	260,226.85	81,338.51	398,975.26	185,084.01	99,198.90	184,922.45	206,600.71	108,534.41	230,093.55	255,391.00	2,846,548.35
ACCOUNTS TO DATE	1410	1407	1405	1411	1411	1411	1414	1415	1435	1452	1487	1765	1765

TO: Kingsley
FROM: Tom
DATE: March 10, 1986
RE: Claims Procedures

Basic Life

1. CDSPI receives advice of death, usually by phone, from the Executor.
2. All details are obtained by phone and an internal memo is sent to Imperial Life with coverage verification. The Executor is asked if an immediate cash payment is required.
3. Imperial confirms the beneficiary, and then CDSPI sends the Death Claim Form to the Executor or beneficiary for completion. The form is returned to CDSPI for completion and sent to Imperial.
4. Imperial Life issues the cheque.

Dependents' Life

1. Same procedure as Basic Life, except that there is no immediate cash option.

Accidental Death and Dismemberment (Death Claim)

1. CDSPI receives advice of death, usually by phone, from the Executor or beneficiary.
2. All details are obtained by phone and an internal memo is sent to Seaboard Life with coverage verification.
3. CDSPI sends the Death Claim Form to the Executor for completion. The form is returned to CDSPI for completion and sent to Seaboard.
4. Seaboard Life issues the cheque.

Accidental Death and Dismemberment (Dismemberment Claim)

1. CDSPI receives advice of claim, usually by phone.
2. All details are obtained and sent to Seaboard Life with coverage verification.
3. A claim form for "specific loss" is sent to the claimant.
4. Forms can be returned either to Seaboard Life or CDSPI.
5. Forms sent to Seaboard, who issues the cheque.

Note: For loss of use claims, Seaboard has the right to wait for 365 days to determine the extent of the loss of use.

Long Term Disability and Office Overhead

1. CDSPI receives advice of a claim, usually by phone.
2. CDSPI sends a claims kit, which includes:
 - a) Instructions "How To Submit A Claim"
 - b) Details of insurance in force
 - c) Notes about disability benefits
 - d) Claim form and Physician's statement
 - e) Return envelope
3. Forms are returned to CDSPI. A check is made to ensure that forms are complete and they are then sent to Imperial Life.
4. Imperial processes the claim and sends the initial cheque to the claimant, together with a supplementary questionnaire if the claim is to be ongoing.
5. Imperial deals directly with the claimant during continued disability.

Minimum time frame for all the above plans:

Mail form to Executor/Claimant -	2 days
Executor/Claimant/Physician completes form -	2 days
Form returned to CDSPI -	2 days
CDSPI sends form to insurance company -	1 day
Insurance company processes form -	2 days
*Cheque for death claim sent to Executor/Beneficiary -	<u>2</u> days
	11 days

*Cheques for disability benefits are not sent until the end of the first month after the elimination period.

The above procedures ensure the most efficient handling of life and disability claims. It is important for CDSPI to have a record of all claims being submitted to ensure that no unnecessary delays occur. Also, to be able to answer enquiries from claimants as to the status of their claim.

The following actions will cause delays in the processing of claims:

- a) Slow reporting of claim to CDSPI;
- b) Claim form not fully complete and has to be returned to claimant;
- c) Claimant does not understand elimination period/cheque issue process;
- d) Slow response from claimant's physician for additional medical information;
- e) Postal delays.

Office Contents, Practice Interruption, General Liability and Malpractice Liability

1. CDSPI receives advice of a claim, usually by phone.
2. The insured is advised of the name of the adjuster to contact.
3. Our initial report form is completed and sent to our consultant/broker.
4. A claims kit is then prepared and sent to the insured. It contains:
 - a) Details of insurance in force.
 - b) Procedure to follow for each type of coverage. Includes instructions to provide all details to the adjuster.
5. If the claim is for Malpractice, a special form, "Dental Professional Liability Insurance Claim Report", is completed by the adjuster.
6. The adjuster is now in control of the claim, and submits his reports to Guardian.
7. If CDSPI receives enquiries from the insured about the status of the claim, we will contact F. Wallace Clancy & Son Ltd. Easily handled enquiries will be dealt with by phone. Complicated enquiries will be made in writing using a General Insurance Claim Enquiry Form.

Apart from similar delays that occur with the Life and Disability plans, there are two main areas that cause unnecessary delays with the General Insurance claims.

1. Failure by the insured to prove his loss.
2. Slow processing of the claim by the adjuster.

Due to the nature of these types of claims, much longer periods of time are usually required to settle a claim. There are usually several parties involved in the repair or replacement of office contents, also the legal process for liability claims.

TKH/dcd

COUNCIL ON NOMINATIONS

REPORT TO THE ANNUAL CDA BOARD OF GOVERNORS MEETING

Members: Dr. P. Ralph Crawford, Chairman, Winnipeg
 Dr. Robert N. Hicks, Vancouver
 Dr. W.R. Thompson, Trenton
 Dr. D.E. Williams, Moncton

1. Council did not meet during the term; business was conducted by correspondence and telephone.
2. Solicitation of nominations for elective offices and vacancies was conducted in accordance with the by-laws and terms of reference of the council.
3. All elective offices and vacancies for the 1986-87 term have been filled by eligible nominees.
4. No Elections are required, as indicated on the appended table.

APPENDIX I

5. **RESOLVED:**

86.106 THAT one ballot be cast to elect those candidates to offices and vacancies where no opposition exists.

ADOPTED

6. The call for nominations, the nomination form and the list of nominees, with biographical information, are appended and comprise part of this report.
7. Council expresses appreciation to the nominators for their assistance in providing nominees, to the candidates for their willingness to serve, and to the staff for their assistance.

COUNCIL ON NOMINATIONS

8. RESOLVED:

86.107 THAT Dr. P. Ralph Crawford be elected as a
member of the Council on Nominations.

ADOPTED

Respectfully submitted,

P. Ralph Crawford, D.M.D.
Chairman, Council on
Nominations

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Nominations with appreciation.

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
<u>Chairman of The Board</u> Dr. N.A. Mancini (Ont.)	Elected annually	Active or Honorary member	1 year	1. Dr. N.A. Mancini (Ont.)
<u>President-Elect</u> Dr. J.R. Robertson (P.E.I.)	Elected annually	Member of Board of Governors	1 year	1. Dr. R.J. Markey (B.C.)
<u>Executive Council</u> Dr. R.J. Markey (B.C.) 1986 (1) Dr. J.N. Wright (Ont.) 1986 (1) Dr. J. Christie (Atl.) 1986	Annual Election to fill expired terms	Member of Board of Governors	2 years	1. Dr. D.E. MacFarlane (B.C.) 2. Dr. K.L. Roach (Ont.) 3. Dr. J.S. Christie (Atl.)
<u>Constitution & By-Laws</u> Dr. M.J.R. Leitch (B.C.) 1986 (1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. M.J.R. Leitch (B.C.)
<u>Education & Accreditation</u> Dr. A. Schwartz, UNIV. 1986 (1) Dr. D. Beck, STUDENT, 1986 Dr. N.J. Layton, NDEB, 1986 (1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. A. Schwartz (Univ.) 2. Mr. R. Barr (Student) 3. Dr. A.F. Labounty (NDEB)

APPENDIX I

NOMINATIONS - CDA ELECTIVE OFFICES - 1986

- 2 -

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
<u>Ethics</u> Dr. G.R. Thordarson (B.C.) 1986 (2) Dr. M.A. Lasko (Man.) 1986 (1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. B.N. Rocky (B.C.) 2. Dr. M.A. Lasko (Man.)
<u>Health Care</u> Dr. D.G. Sage (Ont.) 1986 (1) Dr. G. McFarlane (Nfld) 1986 (1) Dr. R.B. Porter (N.S.) 1986 (1) Vacant (Que.)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. D.G. Sage (Ont.) 2. Dr. G. McFarlane (Nfld.) 3. Dr. R.B. Porter (N.S.) 4. Dr. R.J. Séguin (P.Q.)
<u>Hospital & Institutional Services</u> Dr. J.V. Legault (Que.) 1986 Dr. C. Foster (Prairies Pr.) 1986 (1) Dr. E.L. MacInnis (Atl. Pr.) 1986 (1) Dr. W.S. Walter (B.C.) 1986 (1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. J.V. Legault (P.Q.) 2. Dr. C. Foster (Prairies) 3. Dr. E.L. MacInnis (Atlantic) 4. Dr. W.S. Walter (B.C.)

OFFICE/INCUMBENT	COMMENT	ELIGIBILITY	TERM	NOMINEES-AFFILIATIONS
<u>Information Services</u> Dr. R. Howaniec (B.C.) 1986 (1) Dr. G. Lafrenière (Que.) 1986 (1)	Annual Election to fill expired terms	CDA Member with stipulations	3 years	1. Dr. R. Howaniec (B.C.) 2. Dr. G. Lafrenière (P.Q.)

MEMORANDUM

April 7, 1986

TO: Members of the Board of Governors
Presidents and CEO's - Corporate Members
CDA Council Chairmen
Presidents and Secretaries of Specialty Sections
ACFD - NDEB - RCD(C) -
Provincial Registrars
Presidents - CDHA - CDAA

FROM: Dr. P. Ralph Crawford, Chairman
Nominations Council

SUBJECT: CDA NOMINATIONS 1986-87

-
1. Elections of officers and council personnel for the 1986-87 term will take place during the 1986 Annual Meeting of the Board of Governors in Halifax, on August 22-23, 1986.
 2. Except in the case of nominations to the Council on Nominations itself, nominations from the floor during the Annual Meeting will not be valid unless vacancies are created by withdrawals from the list of nominations as presented by the Council on Nominations. The Board may then make further nominations from the floor.
 3. It is the duty of the Council on Nominations (Article XVI, Section 4 (i), (i-v) to:
 - a) prepare a list of all elective offices to be filled;
 - b) solicit nominations, excluding those for the Council on Nominations;

.../2

- c) rule on eligibility;
- d) make further nominations as necessary, or as Council sees fit;
- e) submit a report to the Annual Meeting.

4. Nominations must be received before MAY 26, 1986.

5. Those entitled to make nominations are:

Members of the CDA Board of Governors
CDA Council Chairmen
Presidents or Secretaries of Corporate Members
Presidents or Secretaries of Specialty Sections

6. Nominees to the Council on Education will include the recommendations of:

The Association of Canadian Faculties of Dentistry
The National Dental Examining Board of Canada
The Royal College of Dentists of Canada
The Conference of Provincial Dental Licensing Authorities
Canadian Dental Hygienists' Association
Canadian Dental Assistants' Association

7. All nominations must be accompanied by:

- (a) Written consent of the nominee.
- (b) A completed conflict of interest statement by the nominee.

Failure to comply with these two requirements will nullify the nomination.

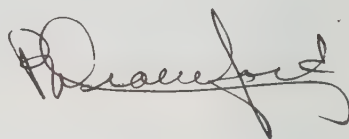
8. Except for Executive Council (as otherwise indicated), election to Councils is for a term of three years, renewable once. Members of the Councils must be Active, Affiliate, or Student Members of the Canadian Dental Association. Affiliate members are not eligible for nominations for election to the Board of Governors or the Executive Council. Student members are not eligible for nomination for election to the Executive Council.

9. Nominations should be accompanied by a brief biographical sketch of the nominee attached to the nomination form.

**PLEASE FORWARD YOUR NOMINATION(S)
WRITTEN CONSENT OF THE NOMINEE'S
WILLINGNESS TO STAND FOR OFFICE
AND A BRIEF BIOGRAPHICAL SKETCH
OF EACH NOMINEE TO:**

**Dr. P. Ralph Crawford, Chairman
Council on Nominations
Canadian Dental Association
1815 Alta Vista Drive
OTTAWA, Ontario, K1G 3Y6**

DEADLINE: May 26, 1986



/ml

M E M O R A N D U M

Le 7 avril 1986

AUX: Membres du Bureau des gouverneurs
Présidents et directeurs généraux des corporations membres
Présidents des conseils de l'ADC
Présidents et secrétaires des sections spécialisées
Association des Facultés de médecine dentaire du Canada
Bureau national d'examen des dentistes du Canada
Collège royal des dentistes du Canada
Registraires provinciaux
Présidents - ACHD - ACAD

DE: Dr. P. Ralph Crawford, président
Conseil des candidatures

OBJET: CANDIDATURES AUX POSTES DE L'ADC POUR 1986-87

-
1. L'élection des dirigeants et des membres des conseils pour l'exercice 1986-1987 se déroulera lors de l'assemblée annuelle du Bureau des gouverneurs qui aura lieu les 22 et 23 août 1986, à Halifax.
 2. Sauf pour les nominations au Conseil des candidatures lui-même, aucune candidature ne peut être présentée directement au cours de l'assemblée annuelle, à moins qu'il s'agisse de combler une vacance créée par le retrait d'un candidat qui avait été inscrit sur la liste du Comité des candidatures. Le Bureau acceptera alors les candidatures mises de l'avant par les participants.
 3. Il incombe au Conseil des candidatures (Article XVI, alinéa 4(i) (i-v):
 - a) de préparer la liste de tous les postes électifs à combler;

.../2

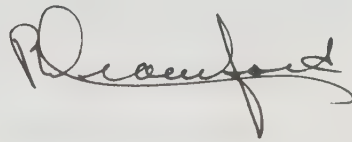
- b) de solliciter les candidatures, sauf au Conseil des candidatures;
 - c) de décider de l'éligibilité des candidats;
 - d) d'appeler d'autres candidats, au besoin ou s'il juge opportun de le faire;
 - e) de faire rapport à l'assemblée annuelle.
4. Les candidatures doivent être reçues avant le 26 MAI 1986.
5. Ont le droit de présenter des candidats:
- les membres du Bureau des gouverneurs de l'ADC,
 - les présidents des conseils de l'ADC,
 - les présidents ou secrétaires des corporations membres,
 - les présidents ou secrétaires des sections spécialisées.
6. Les candidatures au Conseil de l'éducation doivent être recommandées par:
- l'Association des Facultés de médecine dentaire du Canada,
 - le Bureau national d'examen des dentistes du Canada,
 - le Collège royal des dentistes du Canada,
 - la Conférence des organismes de réglementation provinciaux,
 - l'Association canadienne des hygiénistes dentaires,
 - l'Association canadienne des assistantes dentaires.
7. Toute candidature doit être assortie des documents suivants:
- a) l'acceptation par écrit du candidat;
 - b) la déclaration du candidat concernant le conflit d'intérêt.
- Le manquement à ces deux conditions entraîne l'annulation de la candidature.
8. Sauf pour le Conseil exécutif (et à moins d'indication contraire), les membres des conseils sont élus pour un mandat de trois ans, renouvelable une seule fois. Ils doivent être membres actifs, affiliés ou étudiants de l'Association dentaire canadienne. Les membres affiliés ne sont pas éligibles au Bureau des gouverneurs, ni au Conseil exécutif. Les membres étudiants ne sont pas éligibles au Conseil exécutif.

9. Il faut joindre au formulaire de mise en candidature une brève note biographique du candidat.

**Veillez envoyer votre ou vos candidatures,
l'acceptation par écrit,
la déclaration sur le conflit d'intérêt
et la note biographique de chaque candidat au:**

**Dr. P. Ralph Crawford, président
Conseil des candidatures
Association dentaire canadienne
1815, Promenade Alta Vista
Ottawa (Ontario)
K1G 3Y6**

AVANT LE 26 MAI 1986

A handwritten signature in dark ink, appearing to read "P. Crawford", with a stylized, flowing script.

/ml

NOMINATION FORM - CDA

One form must be completed for each candidate. Candidates must be eligible to assume office if elected (see conflict of interest by-law on reverse of this form, and specific regional or other stipulations for nominations on the attached memorandum).

PLEASE CHECK OR COMPLETE ONE OF THE FOLLOWING:

Nomination for: Chairman of the Board _____
President-Elect _____
Executive Council _____
Council on _____

* **NOTE:** Affiliated members are not eligible for nomination to the Board of Governors or Executive Council. Student members are not eligible for nominations to the Executive Council.

PLEASE PRINT OR TYPE THE FOLLOWING:

Candidate's Name _____

Candidate's Address _____
Postal Code _____

It is desirable for a nominee to attach a brief biographical sketch if possible.

IN ACCORDANCE WITH THE STIPULATIONS OF THE CONSTITUTION AS TO REGIONAL OR OTHER REPRESENTATION, AND, AS TO MY ENTITLEMENT TO MAKE NOMINATIONS, I PROPOSE THE ABOVE CANDIDATE FOR NOMINATION.

PLEASE PRINT OR TYPE THE FOLLOWING:

Nominator	Office/Position
-----------	-----------------

Signature _____

****NOTE:** Please notify the candidate's provincial association identifying the candidate and the office, council or committee to which he/she has been nominated.

2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030

ACCORDING TO ARTICLE XXI SECTION 1 OF THE CONSTITUTION, THE FOLLOWING APPLIES:

- a) Every member of the Board of Governors of the Association who has directly or indirectly any interest in any contract or transaction or in any business or undertaking which provides dental supplies or services of any kind to the dental profession, shall declare his material interest in the foregoing. We then will absent himself from discussion and voting on such contract or transaction.
- b) If a Governor has made a declaration in compliance with the above provisions and he has not voted in respect of the contract or transaction, and if he has acted honestly and in good faith, he is not accountable to the Association for any profit or gain realized and the contract or transaction is not voided.
- c) The above provisions apply automatically to the members of the various Committees, and Councils of the Association, including the Executive Council. Each Board and/or Council or Committee member in order to make sufficient disclosure, is required to do so not only to his Council, etc., members but also to the Board of Governors in writing.
- d) All nominees for election or appointment to Councils or Committees of the Association, including the Executive Council shall declare on the nomination form, all possible potential conflicts of interest. These shall be made known to the Board prior to the election.
- e) That, of itself, being a Trustee of the CDA administered insurance and investment plans and/or of itself being a representative of the CDA to the Board of Canadian Dental Service Plans Incorporated shall not constitute a potential conflict of interest for a current member or a candidate for election to the Executive Council of the CDA.
- f) A conflict of interest shall exist where a member of the Board of the CDA or any of its Councils and Committees is privy to information that could be construed to be confidential and of benefit to that individual or any organization with which he may be associated. In such situations such a member shall be required to give an undertaking that such information be kept confidential.

ARTICLE XXI SECTION 1 OF THE CONSTITUTION APPEARS ON THE REVERSE OF THIS NOMINATION FORM. THIS ARTICLE DEALS WITH POSSIBLE POTENTIAL CONFLICTS OF INTEREST.

NOMINEE WILL PLEASE INITIAL ONE OF THE FOLLOWING:

- A) I have no known possible potential conflict of interest _____
- b) I have a possible conflict of interest _____
if b) please explain potential conflict on the reverse of
this form.

I agree to permit my nomination and qualify by Active ___ Affiliate ___
Student ___ Membership in the CDA

Membership in _____ (Corporate Member)

NAME OF ORGANIZATION RECOMMENDING THIS NOMINATION _____

SIGNATURE OF NOMINEE _____

- 4 -

- g) The Board shall be the final authority on any disputed conflict of interest.

PLEASE INDICATE BELOW ANY POSSIBLE POTENTIAL CONFLICT OF INTEREST:

Return this completed form by MAY 26, 1986 to:

Dr. P. Ralph Crawford, Chairman - Council on Nominations
Canadian Dental Association, 1815 Alta Vista Dr.
OTTAWA, Ontario, K1G 3Y6

CURRICULUM VITAE

Name _____

Address _____

_____ Postal Code _____

Office Telephone No. _____ Area Code _____

(Please limit your curriculum vitae to a maximum of two (2) pages)

**NOMINATIONS
1986**

I. President-Elect

Term: 1 year
Eligibility: Member of the Board of Governors

1. _____

II. Chairman of the Board

Term: Elected annually
Eligibility: Active or Honorary Member (may hold no other
elective office during his tenure as Chairman)

Incumbent: N.A. Mancini, Hamilton
Eligible for re-election

1. _____

III. Executive Council - 9 members

Term: 2 years: renewable twice
Eligibility: Member of the Board of Governors

Incumbents: P.R. Crawford, Past-President
B.W. Holmes, President
J.R. Robertson, President-Elect
G. Dubé, Quebec
E.F. Allison, Alberta 1987 (1)
J. Christie, Nova Scotia
J.W. Niedermayer, Saskatchewan 1987 (2)
J.R. Markey, Vancouver, 1986 (1)
J.N. Wright, Ontario, 1986 (1)

Summary:

The Executive Council shall consist of the President, Immediate Past-President, President-Elect and six additional members. The President-Elect and six additional members shall be elected by the Board of Governors from its membership. The province from which a member is licensed at the date of the Annual Meeting shall determine the province from which the candidate has been drawn. The six additional members shall consist of one each from the following regions:

- (a) Province of British Columbia
- (b) Province of Alberta
- (c) Provinces of Saskatchewan - Manitoba
- (d) Province of Ontario
- (e) Province of Quebec
- (f) Provinces of New Brunswick, Nova Scotia,
P.E.I. and Newfoundland

Dr. P.R. Crawford is retiring as Past-President. Drs. J.N. Wright and J.R. Markey are completing their first terms and are eligible for re-election.

Dr. G. Dubé is a presidential appointment to replace Dr. J.C. Giguère. Dr. Giguère's term would have ended in 1987.

Dr. J. Christie is completing the unexpired term of Dr. J.R. Robertson, which ends at the 1986 Annual Meeting.

If an incumbent in his non-elective year is elected President-Elect, the uncompleted term will be filled by presidential appointment.

3 to be elected 1. _____ B.C.
2. _____ Ontario
3. _____ Atl. Prov.

IV. Council on Constitution & By-Laws: 4 members

Term: 3 years: renewable once

Incumbents: G.H. Peacock, Saskatoon, 1988 (2), Chairman
B.M. Jackson, Kitchener, 1987 (2)
M.J.R. Leitch, British Columbia, 1986 (1)
M.J. Cripton, New-Brunswick, 1987 (1)

Summary

Dr. M.J.R. Leitch is completing his first term and is eligible for re-election.

1 to be elected 1.

V. Council on Dental Materials and Devices: 8 persons

Term: Nominated by the Executive Council and appointed by the Board of Governors annually.

Incumbents: R.Y. Barolet, Ste-Foy, Chairman
P.C. Desautels, Montreal
L.N. Johnson, London
D.W. Jones, Halifax
D. Smith, Toronto
P.T. Williams, Winnipeg
R. Roydhouse, Vancouver

VI Council on Education and Accreditation: 17 members

Term: 3 years: renewable once

Incumbents:	A. Schwartz, Winnipeg, 1986 (1), Chairman	UNIV
	M.A. Boyd, Vancouver, 1988 (2)	UNIV
	B.S. Graham, Halifax, 1987 (1)	UNIV
	I. Vogan, Halifax, 1988 (1)	NON-UNIV
	G.W. Burgman, Kirkland Lake, 1988 (2)	NON-UNIV
	M. Jahjah, Montreal, 1988 (2)	NON-UNIV
	E.W. McIntyre, Edmonton, 1988 (2)	NON-UNIV
	G. Thompson, Edmonton, 1988 (1)	ACFD
	G.S. Beagrie, Edmonton, 1987 (2)	RCD(C)
	K.F. Pownall, Toronto, 1988 (2)	REGISTRAR
	G.R. Thordarson, Vancouver, 1987 (1)	REGISTRAR
	H.M. Dick, Edmonton, 1988 (1)	NDEB
	N.J. Layton, Truro, 1986 (1)	NDEB
	D. Beck, Surrey, 1986	STUDENT
	(1 year: renewable annually)	
	J. Robarts, Toronto, 1987 (1)	LAY REP.
	K. MacDonald, Halifax, 1988 (1)	CDHA
	M. Paquin, Vancouver, 1988 (1)	CDA

Summary:

Dr. A. Schwartz is completing his first term and is eligible for re-election as a UNIV rep.

Dr. D.Beck is completing a one-year term and a nomination is required for a STUDENT representative.

Dr. N.J. Layton is completing his first term as an NDEB representative and is eligible for re-election

3 to be elected	1. _____	UNIV
	2. _____	STUDENT
	3. _____	NDEB

VII. Council on Ethics: 5 members

Term: 3 years: renewable once

Incumbents:	G.R. Thordarson, Vancouver, 1986 (2), Chairman
	M.A. Lasko, Winnipeg, 1986 (1)
	W.G. Leggett, Ontario, 1988 (2)
	G.G. Turner, Glace Bay, 1987 (1)
	B.G. Saik, Calgary, 1988 (1)

Summary:

Dr. G.R. Thordarson is completing his second term and a nomination is required to fill this vacancy.

Dr. M.A. Lasko is completing his first term and is eligible for re-election.

2 to be elected 1. _____
 2. _____

VIII. Council on Health Care: 14 members

Term: 3 years: renewable once

Incumbents: A. Toeman, Quebec, 1988 (2), Chairman
D.G. Sage, Ontario, 1986 (1)
G. McFarlane, Newfoundland, 1986 (1)
R.B. Porter, Nova Scotia, 1986 (1)
W. Allen, P.E.I., 1988 (1)
T.D. Fantin, British Columbia, 1988 (1)
K.I. Hamilton, Saskatchewan, 1988 (2)
D.E. Upton, Alberta, 1988 (1)
L-Col. P.R. McQueen, Ontario, CFDS, 1988 (2)
J.C. Rooney, New Brunswick, 1988 (1)
K.R. Skinner, Manitoba, 1988 (2)
P. Larder, Halifax, 1988 (1)
S. Mader, Seattle, 1988 (1)
Vacant, (Quebec)

Summary

Drs. D.G. Sage, G. McFarlane and R.B. Porter are completing their first terms and are eligible for re-election.

The position of Quebec representative has been vacant since Dr. Toeman was appointed Chairman and a nomination is required for the Quebec representative.

4 to be elected

1. _____ Ontario
2. _____ Nfld
3. _____ N.S.
4. _____ Quebec

IX. Council on Hospital and Institutional Services: 6 members

Term: 3 years: renewable once

Incumbents: J. Gryfe, Weston, 1987 (2), Chairman
C. Foster, Winnipeg, 1986 (1)
J. Hardie, Ottawa
E.L. MacInnis, Halifax, 1986 (1)
J.V. Legault, Montreal
W.S. Walter, Vancouver, 1986 (1)

Summary

The Council on Hospital Services shall consist of five members representative of the Atlantic Provinces, Quebec, Ontario, the Prairie Provinces and British Columbia.

Dr. J. Hardie is filling the vacancy of the chairman for 1986-1987.

Dr. J.V. Legault is completing the unexpired term of Dr. Trudel.

Drs. C. Foster, E.L. MacInnes and W.S. Walter are completing their first terms and are eligible for re-election.

4 to be elected	1. _____	Prairie Pr.
	2. _____	Atl. Pr.
	3. _____	Quebec
	4. _____	B.C.

X. Council on Information Services: 5 members

Term: 3 years: renewable once

Incumbents: Y. Kamachi, Ontario, 1987 (2), Chairman
T. Koltek, Prairie Provinces, 1987 (2)
C. Leblanc, Atlantic Provinces, 1987 (2)
R. Howaniec, British Columbia, 1986 (1)
G. Lafrenière, Quebec, 1986 (1)

Summary

The Council on Information Services shall consist of five members representative of the Atlantic Provinces, Quebec, Ontario, the Prairie Provinces and British Columbia.

Drs. R. Howaniec and G. Lafreniere are completing their first terms and are eligible for re-election.

2 to be elected 1. _____ B.C.
2. _____ Quebec

XI. Council on Insurance and Investment

The Canadian Dental Association has delegated to the Canadian Dental Service Plans Inc. the function of the Council on Insurance and Investment as a result of an agreement between the two organizations. This agreement is to be reviewed annually by the Board of Governors of the Canadian Dental Association and the Canadian Dental Services Plans Inc.

None to be elected

XII. Council on Nominations: 3 members plus Past-President as Chairman

Term: 3 years

Incumbents: P.R. Crawford, Manitoba, Chairman
D.E. Williams, New Brunswick, 1986
W.R. Thompson, Ontario, 1987
R.N. Hicks, British Columbia, 1988

Summary

The Council on Nominations shall consist of three members elected by the Board at its Annual Meeting, pursuant to Article X, Section 6 of the By-laws, together with the Past-President, who shall be Chairman. The membership should be geographically representative of the Association and shall include one or more Past-Presidents.

Dr. D.E. Williams is completing his term and nominations will be received from the floor at the Annual Meeting to fill one vacancy.

1986/02/14
/m]

CHAIRMAN OF THE BOARD

CURRICULUM VITAE

Name N.A. Mancini
Address 280 Barton Street East
Hamilton, Ontario Postal Code L8L 2X3
Office Telephone No. 529-0041 Area Code 416

Personal Married - Josephine, October 10, 1949
3 sons: Michael Gerard, Nicholas Anthony Jr.,
and John Patrick

Education Elementary - St. Ann's School, Hamilton
Secondary - Cathedral High School, Hamilton
B.A. (Chemistry, Physics, Biology) - University
of Toronto
D.D.S. - University of Buffalo

Memberships Served on original Foundation Committee for the
Hamilton Theatre Auditorium Centre
Served on Hamilton Urban Renewal Committee
Served on Staff of Hamilton Civic Hospitals
Served (6 years) on the Board of Governors of
Hamilton Civic Hospitals
Served one year on the Board of Directors of
Social Planning and Research Council
Past-Chairman of the Canadian Catholic School
Trustees Association (C.C.S.T.A.)
Past-Chairman of the Ontario Separate School
Trustees Association (O.S.S.T.A.)
Currently on Executive Council of O.S.S.T.A.
Past-Chairman of the Ontario School Trustees
Council (O.S.T.C.) which includes 5 Trustees'
Associations of Ontario
Fellow of the International College of Dentists
(FICD)
Dominion Council of Health (3 years)
Past-Chairman of Hamilton-Wentworth Roman
Catholic Committee
Accorded Papal Honour (Made a K.S.G.)
(Knighthood) Knight of St. Gregory
Past-President of the Hamilton Academy of
Dentistry
Serving as Chairman of the Board - ODA
Serving as Chairman of the Board - CDA
Past Grand Knight - Knights of Columbus,
Hamilton
Pierre Fauchard Academy

PRESIDENT-ELECT

CURRICULUM VITAE

Name Ron J. Markey
Address 6180 Blundell Road, Suite 210
Richmond, B.C. Postal Code V7C 4W7
Office Telephone No. 271-7620 Area Code 604

Place of Birth Montreal, Quebec
Date of Birth January 1, 1945
Married with four children

Education

Loyala College of Montreal, B.A., Biology-Chemistry, 1965
McGill University, Montreal, D.D.S., 1969
University of Washington, Seattle, M.S.D. Orthodontics, 1974

Professional Employment Record

Private General Dental Practice - Montreal, 1969-72
Demonstrator, Departments of Paedodontics and Operative
Dentistry, McGill, 1969-72
Assistant Professor, U.B.C., 1974-75
Sessional Lecturer, U.B.C., 1975-80
Private Orthodontic Practice, Richmond and Vancouver, 1975 to
present

Professional Activities

Vancouver & District Dental Society
Canadian Association of Orthodontics
Van Bel Orthodontic Study Club
Pacific Coast Society of Orthodontics
Chairman - Megaclinic, Annual Meeting, 1978
Assistant Program Chairman - PCSO Northern Meeting, 1979-80
Program Chairman - PCSO Northern Meeting, 1980-81
Constitution and By-law Committee, 1983-85
Interspecialty Dental Society of B.C.
Secretary-Treasurer, 1979-80
Representative to College Council, 1979-80
B.C. Society of Orthodontists
Treasurer, 1977-78
Secretary, 1978-79
Vice-President, 1979-80
President, 1980-81

College of Dental Surgeons of B.C.

Treasurer, 1980-81

Vice-President, 1981-82

President, 1982-83

President, 1983-84

Nominations Committee Chairman, 1984-85

Canadian Dental Association

B.C. Governor, 1981 to present

Executive Council, 1984 to present

United Way Campaign Cabinet (Lower Mainland, B.C.)

Chairman, Professional Development Division, 1986

EXECUTIVE COUNCIL

CURRICULUM VITAE

Name D.E. MacFarlane
Address 101-2732 West Broadway
Vancouver, B.C. Postal Code V6K 2G4
Office Telephone No. 736-7371 Area Code 604

- D.M.D. - Manitoba - 1966
- Married, two children
- President, College of Dental Surgeons of B.C. - 1977-79
- Chairman, CDA Third Party Dental Plans committee

EXECUTIVE COUNCIL

CURRICULUM VITAE

Name Kevin L. Roach

Address 351 Pembroke Street West

Pembroke, Ontario Postal Code K8A 5N5

Office Telephone No. 735-5333 Area Code 613

Personal Birth - April 5, 1948
Married -wife, Anne
Children: Murray - 11, Maureen - 9, Rebecca - 5,
and Meghan - 3

1969 Graduate of Laurentian University - B.Sc.

1972 University of Toronto Student Governor to the
Ontario Dental Association

1973 Chairman - 45th Canadian Dental Students
Conference - Vancouver
Graduate of University of Toronto - D.D.S.
Oral Diagnosis Award

1975-77 President, Renfrew County Dental Society

1977 ODA Board of Governors

1978 Elected Executive Council, ODA

1979 Elected CDA Governor

1981 Re-elected CDA Governor
Executive Liaison to DPAC and Education Committees

1983 President, Ontario Dental Association

1984 Re-elected CDA Governor

Community Involvement Past Director, Kinsmen Club
Past Director, United Appeal
Past-President,
Renfrew-Nippissing-Pembroke Liberal
Association
Chaired four campaigns to promote
fluoridation of Pembroke's water supply

EXECUTIVE COUNCIL

CURRICULUM VITAE

Name J.S. Christie

Address Suite 210 - 1595 Bedford Highway

Bedford, N.S. Postal Code B4A 1E7

Office Telephone No. 835-5286 Area Code 902

PLEASE SEE ATTACHED PAGES FOR C.V.

DR. JOHN S. CHRISTIE

PRESENT UNIVERSITY RANK: Lecturer

OFFICE ADDRESS:

a) Dalhousie

Faculty of Dentistry
Dalhousie University
Room 5198
Halifax, Nova Scotia

Telephone: 424-2247

b) Private Practice

1595 Bedford Highway
Suite 210
Bedford, Nova Scotia
B4A 1E7

Telephone: 835-5286

HOME ADDRESS: 18 Oak Hill Drive
Halifax, Nova Scotia
B3M 2V2

Telephone: 443-2249

CITIZENSHIP: Canadian

DATE OF BIRTH: April 30, 1945

MARITAL STATUS: Married: wife - Jane

CHILDREN: One son: Ian

EDUCATION:

High School

Queen Elizabeth High School
Halifax, Nova Scotia
Grade XI
1962

EDUCATION: (Cont'd)

University

Dalhousie University
Halifax, Nova Scotia
1962 - 1971

Dental School

Dalhousie University
Faculty of Dentistry, Halifax, Nova Scotia
D.D.S.
1971

HONOURS AND AWARDS:

Fellow - International college of Dentists, 1985

ACADEMIC APPOINTMENTS:

Instructor, Part-time
Dalhousie University
Halifax, Nova Scotia
1972 - 1978

Lecturer, Part-time
Dalhousie University
Halifax, Nova Scotia
1978 - 1985

Responsible for Dental Hygienist
Restorative Program, Pre-Clinical
Dalhousie University
Halifax, Nova Scotia
1976 - 1981

Clinical Instructor
Nova Scotia Institute of Technology
1977 - 1985

Clinical Instructor - 3rd and 4th year Dental Students
1981 - 1985

Assistant Professor
Faculty of Dentistry
Dalhousie University
1985 to present

UNIVERSITY COMMITTEE APPOINTMENTS:

Dalhousie University
Table Clinic Judge
1978

Admissions Committee
Dalhousie University
Member 1975 - 1978

Ad Hoc Committee to advise the Dean on the appointment of a Chairman
for the Department of Pediatrics and Community Dentistry
Dalhousie University
Member - 1978

DAU Committee
Dalhousie University
Member - 1981

Committee to Review Status of Expanded Duty Dental Hygiene Program
Member - 1982 to 1983

Committee to Establish an Alumni Recognition Process
Chairman, - 1983

Outstanding Alumni Committee,
Chairman 1983/84

Alumni Relations Committee
Chairman 1984 - Present

HOSPITAL APPOINTMENTS:

Courtesy Staff
I.W.K. Hospital
Halifax, Nova Scotia
1971 to Present

PROFESSIONAL EXPERIENCE:

a) Private Practice

Private General Practice
1971 - present

PROFESSIONAL EXPERIENCE: (Cont'd)

b) Government

Teaching Staff
Dental Assistant Program
Nova Scotia Institute of Technology
1977 - 1985

Advisory Committee
Dental Assistant Program
Nova Scotia Institute of Technology
1981 - 1986

Member, Working Group on the Practice of Dental Hygiene
Health and Welfare
Government of Canada

NATIONAL, PROVINCIAL, AND STATE DENTAL BOARDS:

a) General

National Dental Examining Board, Nova Scotia

b) Current Licences

Provincial Dental Board of Nova Scotia

PROFESSIONAL SOCIETIES:

Nova Scotia Dental Association, 1971 - Present
Canadian Dental Association, 1971 - Present
Halifax County Dental Society, 1971 - Present
Canadian Society of Forensic Science, 1974 - Present

POSITIONS HELD IN PROFESSIONAL ORGANIZATIONS:

Chairman
Dental Care Systems Committee
Nova Scotia Dental Association
1975 - 1977

Executive
Nova Scotia Dental Association
1975 - to Present

President
Nova Scotia Dental Association
1978 - 1979

POSITIONS HELD IN PROFESSIONAL ORGANIZATIONS: (Cont'd)

Nova Scotia Representative to CDA Journal
1978 - 1983

Ad Hoc Committee on Concerns and Responsibilities
of Dental Bodies Having Statutory Powers
Canadian Dental Association
1979

Co-Chairman
CDA National Convention Committee
Halifax, Nova Scotia
1979 - 1980

Board of Governors
Nova Scotia Member
Canadian Dental Association
1980 - present

Dental Advisory Committee to
Nova Scotia Health Insurance Commission
1982 - to present

N.S.D.A. Representative to N.S. Government Dental Services Review
Commission 1982

Member of the Working Group on Dental Hygiene - Department of Health
and Welfare Canada
1982 to present

N.S.D.A. Delegate to C.anadian Dental Services Plans Inc.
Annual Meeting
1983/84

Executive Council
Canadian Dental Association
1985 to present

COMMUNITY ACTIVITIES:

President, Atlantic Canada Aviation Museum Society, 1984/85

Nova Scotia Rifle Association, 1982

Cerebral Palsey Association of Nova Scotia, 1974 to Present

Dental Representative
Fund Devices of the Canadian Diabetic Association

ABSTRACTS AND MINOR PUBLICATIONS:

Nova Scotia Dental Association Contributor to
Canadian Dental Association Journal 1978 - 1983

CONSTITUTION AND BY-LAWS

CURRICULUM VITAE

Name M.J.R. Leitch
Address 22-1710 Ellis Street
Kelowna, B.C. Postal Code V1Y 2B5
Office Telephone No. 762-2440 Area Code 604

Personal Born - Melfort, Saskatchewan
Married - Joan
3 children - Malcolm, Ian, and Melanie

Education B.A. - University of Saskatchewan - 1950
B.D.S. - McGill University - 1955

Practice Private practice in Kelowna, B.C. - 1955

Dental Positions President and Secretary of the Kelowna and District Dental Society
President and Secretary of the Thompson Okanagan Dental Society
Elected representative to the College of Dental Surgeons of British Columbia - 1977
Elected to the College of Dental Surgeons of British Columbia Executive Council - 1978
Elected Vice-President of the College of Dental Surgeons of British Columbia - 1980
President of the College of Dental Surgeons of British Columbia - 1981

Associations Past-President of the Central Okanagan District Boy Scouts Association
Member of the Board of Governors of Shawnigan Lake School for Boys
Active in the United Church
Past-President of the Kelowna Rotary
Paul Harris Fellow in Rotary

Interests Alpine skiing, golf and gardening

EDUCATION AND ACCREDITATION

CURRICULUM VITAE

Name Albert F. Labounty
Address 301 - 1890 Cooper Road
Kelowna, B.C. Postal Code V1Y 8B7
Office Telephone No. 860-8900 Area Code 604

- Graduate, McGill University Dental School - 1966
- Past-President - Kelowna & District Dental Society
- Past-President - Thompson Okanagan Dental Society
- Past Council Member - B.C. College of Dental Surgeons
- Past Executive Member - B.C. College of Dental Surgeons
- Past Examiner - B.C. Dental Examining Board
- Past Chairman - B.C. Dental Examining Board
- Political Liaison with Provincial M.L.A. for B.C. College of Dental Surgeons
- Examiner - National Dental Examining Board
- B.C. Representative - National Dental Examining Board
- Member - Walter K. Sproule Gold Foil Study Club
- Member - American Academy of Gold Foil Operators
- Member - K.E. Murchie Restorative Study Club
- Member - Academy of Operative Dentistry
- Member - Canadian Dental Association

ETHICS

CURRICULUM VITAE

Name Brian N. Rocky

Address 1125 West 8th Avenue

Vancouver, B.C. Postal Code V6H 3N4

Office Telephone No. 736-3621 Area Code 604

Graduate of the University of B.C. - B.Sc. (1970)

Graduate of the University of B.C. - D.M.D. (1973)

Private Practice in Richmond, B.C. since 1973

Faculty member (part-time) at UBC since 1976

Deputy-Registrar of the C.D.S.B.C. since 1984

Member of numerous College committees over the years

President, Dental Alumni Association of U.B.C. - 1982-83

Currently member, Sub-committee on Alternate Delivery System of Third Party Committee, Canadian Dental Association

ETHICS

CURRICULUM VITAE

Name Michael Anthony Lasko
Address 12 Seabrook Cove
Winnipeg, Manitoba Postal Code R3J 3G2
Office Telephone No. 589-3190 Area Code 204

Place/Date of Birth	Toronto, Ontario - 1944
Marital Status	Married (Judy) - 1967
Children	Son David - Grade IX Daughter Cathy - Grade VII
Early Education	Gordon Bell High School - 1961 - Grade XII
Pre-Professional	University of Manitoba - 1962-1963 Faculty of Science
Professional	University of Manitoba - 1967 - D.M.D. General Practice - Winnipeg - 1967 to present Part-time Clinical Demonstrator, University of Manitoba Faculty of Dentistry in Restorative Dentistry - 1979-1981
Memberships	Winnipeg Dental Society Manitoba Dental Association Mediation - Peer Review Committee - 1977-1980 Social Allowance Review Committee - 1980-1983 Registrar - Manitoba Dental Association - 1983 Xi Psi Phi Fraternity Alumni Association, University of Manitoba

HEALTH CARE

CURRICULUM VITAE

Name David G. Sage
Address 379 Hunter Street
Woodstock, Ontario Postal Code N4S 4G3
Office Telephone No. 539-9825 Area Code 519

- Graduated University of Toronto - 1974
- Ontario Dental Association Governor representing Sault Ste-Marie - 1974-1978
- Ontario Dental Association Governor representing Oxford Dental Society - 1982-1985
- Member - Dental Practice Advisory Committee of the Ontario Dental Association - 1978-1986
- Chairman, DPAC - 1981-1983
- Member - Health Care Council of the Canadian Dental Association - 1984-1986

HEALTH CARE

CURRICULUM VITAE

Name Gerry McFarlane
Address P.O. Box 187
Grand Falls, Newfoundland Postal Code A2A 2J4
Office Telephone No. _____ Area Code _____

Personal Born - November 1, 1940, St. John's Newfoundland
Education B.Sc. - St. Dunstan's University, P.E.I. - 1962
D.D.S. - Dalhousie University, Halifax, N.S. - 1966
Practice General Dentistry - Grand Falls, Nfld. - 1968 to
present
Chief of Service - Dentistry - Central Nfld. Hosp.
(local Hosp.) - 1974-1982
Associations President, Newfoundland Dental Association -
1979-1981
Member of various committees with the Newfoundland
Dental Association during the past years

HEALTH CARE

CURRICULUM VITAE

Name R.B. Porter
Address 33 Greening Drive
Antigonish, N.S. Postal Code B2G 1R1
Office Telephone No. 863-1222 Area Code 902

Education

B.A. (ED), Memorial University, 1966
B.Sc., Memorial University, 1967
D.D.S., Dalhousie University, 1971

Association Membership

President, Amalgamator Society, 1968
Antigonish Lions Club, 1977
Member, Board of Appeal, Department of Social Services,
Province of Nova Scotia, 1980
Member, Dental Care Systems Committee, Nova Scotia Dental
Association, 1979
Member, Economic Review Committee, Nova Scotia Dental
Association, 1980-1986
Chairman, Economic Review Committee, 1980-1982
President, Antigonish Camp, Gideons International
Nova Scotia Dental Association President-Elect, 1985-1986
CDA Council on Health Care, 1983-1986

HOSPITAL AND INSTITUTIONAL SERVICES

CURRICULUM VITAE

Name J. Victor Legault
Address 5757, avenue IV Descelle 336
Montréal, Québec Postal Code H3S 2C3
Office Telephone No. 342-2157 Area Code 514

Naissance Montréal 1936

Education

Université de Montréal 1951-1955
Diplôme obtenu: B.A. en Sciences

Université de Montréal 1958-1962
Diplôme obtenu: D.D.S.

Université de Rochester N.Y. 1963-1965
Diplôme obtenu: Certificate in Pedodontics

Cours Post-Gradués:
1967 - M.I.T. Boston: Croissance
1972 - Université de Mexico: Orthodontie
1976 - University of Ann Harbour Michigan: Croissance

Expérience professionnelle

Assistant professeur, Université de Montréal -
Pédodontie 1965-1970
CDA Caribbean Program, Ste Lucie, W.I. Eté 1976
Chargé de cours, Université de Montréal - Pédodontie
1979 ...
Pratique privée en pédodontie: 1965 ...

Publications scientifiques

Acta Odontologica helvetica: Suisse 1965
Journal of the American Society of Dentistry for
Children 1970
Journal de l'Association dentaire canadienne 1972
Journal de l'Association dentaire canadienne 1980

Conférences

Journées dentaires du Québec, Montréal 1975
 Congress of Dentistry for Children, Toronto 1975
 Association dentaire canadienne, Québec 1979
 Fédération dentaire internationale, Paris 1979
 Congress of Dentistry for the Handicapped, Jerusalem
 1980
 4e Congrès canadien de Pédiodontie, Toronto 1981
 Les Journées dentaires, Montréal 1984

Fonctions courantes

Fédération des dentistes spécialistes du Québec,
 président
 Cercle d'Etudes Fauchard, secrétaire
 Comité d'évaluation médicale et dentaire, Hôpital
 Marie-Enfant
 Conseil des médecins et dentistes, Hôpital Marie-Enfant
 Chef du service de dentisterie pédiatrique, Hôpital
 Marie-Enfant
 Comité des services hospitaliers et agrément du
 Programme de spécialisation en médecine dentaire, Ordre
 des dentistes du Québec.

HOSPITAL AND INSTITUTIONAL SERVICES

CURRICULUM VITAE

Name Colin C. Foster
Address 1406 - 233 Kennedy Street
Winnipeg, Manitoba Postal Code R3C 3J5
Office Telephone No. 943-7534 Area Code 204

- Certified Oral & Maxillofacial Surgeon
- B.D.S. - St. Andrews, Scotland, 1968
- M.Sc., Oral and Maxillofacial Surgery - Dalhousie University, N.S., 1973
- F.R.C.D.(C) - 1976
- President, Manitoba Society of Oral & Maxillofacial Surgeons
- Past Chairman - Manitoba Dental Association Specialists' Committee
- Past Chairman - Manitoba Dental Association Review Committee
- Member - Hospital Services Committee, MDA
- Member - Economics Committee, MDA
- Past Councillor - Canadian Association of Oral & Maxillofacial Surgeons Executive
- Chairman - CAOMS Hospital Services Committee
- Prairie Councillor (current) - CDA Council on Hospital and Institutional Services
- Licences to Practise - Manitoba and The United Kingdom

HOSPITAL AND INSTITUTIONAL SERVICES

CURRICULUM VITAE

Name Edmund L. MacInnis

Address 559 East River Road

New Glasgow, N.S. Postal Code B2H 5E3

Office Telephone No. 752-4923 Area Code 902

PLEASE SEE ATTACHED PAGES FOR C.V.

EDMUND L. MACINNIS

OFFICE ADDRESS:

559 East River Road
P.O. Box 339
New Glasgow, Nova Scotia
B2H 5E3

Telephone: 752-4923 (Office)
752-8311 (Hospital)

HOME ADDRESS:

R.R.#1 Merigomish
Pictou County, Nova Scotia
B0K 1G0

Telephone: 926-2992

CITIZENSHIP:

Canadian

DATE OF BIRTH:

August 4, 1940

MARITAL STATUS:

Married

EDUCATION:

1962-1964 - St. Francis Xavier University: Science (PreMed)
1964-1968 - D.D.S., University of Toronto
1974-1977 - Diploma (Oral & Maxillofacial Surgery) Madigan
Army
1979 - Diplomate, ABOMS
1980 - Fellowship (F.R.C.D.), Royal College of Dentists
of Canada

POSITIONS HELD:

1968-1972 - General Dental Officer, CFDS, Halifax
1972-1974 - General Dental Officer, CFDS, West Germany
1972-1973 - PMC Officers Mess, CFB(E), Baden
1974-1977 - Oral and Maxillofacial Surgery Resident, Madigan
Army Medical Center, Tacoma, Wa.
1977-1981 - Chief of Oral and Maxillofacial Surgery,
CF Hospital, Halifax
1980-1981 - Base Dental Officer, CFB Halifax, N.S.
1980-1981 - Assistant Professor, Department of Oral
Diagnosis & Oral Surgery, Part-time, Dalhousie
University

POSITIONS HELD: (Continued)

- 1982 - Assistant Professor, Department of Oral
Diagnosis & Oral Surgery, Full time, Dalhousie
University
- 1984 - A/Director Clinical Undergraduate Education
(Oral Surgery) Dalhousie University
- 1985 - Active staff Aberdeen Hospital
- 1986 - Head of Dental Department - Aberdeen Hospital
- 1986 - Assistant Professor (Honorary), Department of
Oral Surgery, Dalhousie University

HOSPITAL AFFILIATIONS:

- CF Hospital Halifax - Chief of Oral and Maxillofacial
Surgery, 1977-1981
 - Treasurer, Medical Staff, 1978-1979
 - Chairman Entertainment Committee,
1977-1979
 - Chairman Infection Control Committee,
1979-1981
 - Consultant, Oral and Maxillofacial
Surgery, December, 1982
- Victoria General Hospital
 - Courtesy Staff, 1980-1982
 - Active Staff, 1982
- IWK Hospital for Children
 - Temporary appointment active staff,
December, 1982
 - Active Staff 1984
- Aberdeen Hospital, New Glasgow
 - Active Staff, 1985

PRIZES AND AWARDS:

- Murphy Sword, Honour Cadet 1964, Armour Corps School,
Camp Borden
- Honour Cadet, 2nd Phase DOTP, CFDS School, 1966
- Pedodontic Prize, University of Toronto, 1968
- C.D. (Canadian Forces Decoration) 1974

DENTAL LICENSURE AND CERTIFICATION:

- 1968-1980 - General Dentistry, Ontario
- 1977-1980 - Oral Surgery, Ontario
- 1977-1985 - Oral Surgery, Nova Scotia # 03-77-29-040
- 1979 - Diplomate, American Board of Oral &
Maxillofacial Surgery
- 1980 - Fellowship, Royal College of Dentists of Canada

SOCIETIES AND ORGANIZATIONS:

- 1977-1985 - Halifax County Dental Society, Member
- 1977-1986 - Nova Scotia Dental Association, Member
 - Canadian Dental Association, Member
 - Canadian Association of Oral and Maxillofacial Surgeons, Member
 - Royal College of Dentists of Canada, Fellow
 - American Board of Oral and Maxillofacial Surgery, Member
 - Society of Dental specialists of Nova Scotia, Member
- 1968-1980 - Ontario Dental Association, Member
 - Canadian Craniofacial Society
- 1984 - American Association of Oral and Maxillofacial Surgeons (Provisional Member)
- 1985 - American Association of Oral and Maxillofacial Surgeons, Member
- 1985-1986 - North Nova Scotia Dental Society, Member

OTHER PROFESSIONAL ACTIVITIES:

- 1981-1986 - Committee Member of the Drug and Therapeutics Committee of the Health Services and Insurance Commission of N.S.
- 1983-1986 - CDA council on hospital and institutional services

CURRENT RESEARCH: - Nothing Active

Past Research - 1982-1983:

A study on the duration of Post Operative Analgesia utilizing Bupivacaine HCl.

PUBLICATIONS:

1. MacInnis, E.L., Horizontal mandibular cuspid impaction and contralateral compound composite odontoma. CFDS Quarterly 14:7, Jan. 1974.
2. McCurdy, J.A., MacInnis, E.L., Hays, L.H., Fatal mediastinitis after a dental infection. J. Oral Surg 35:726, Sept. 1977.
3. MacInnis, E.L., Hyperbaric Oxygen Therapy in Oral Surgery, 1983

PAPERS PRESENTED:

1. 1969 - Pin retained amalgam table clinic, Atlantic Provinces Dental Convention, Summerside, P.E.I.
2. 1974 - Surgical endodontics, U.S. Army Europe General Dentistry Annual Meeting, Frankfurt, W. Germany.
3. 1976 - Surgical infections of odontogenic origin, Madigan Army Continuing Education.
4. 1977 - Infection Control in outpatient practice, Fairbanks, Alaska Dental Society.
5. 1978 - Parameters of orthognathic surgery, CFDS School, Borden, Ontario.
6. 1979 - Head and neck infections or odontogenic origin, NDMC, Ottawa, Ontario
7. 1979 - Parameters of intravenous sedation, 12 Dental Unit Annual Conference.
8. 1980 - Current Concepts in antibiotic usage, Rhine Valley Dental Society, Lahr, W. Germany.
9. 1980 - Current procedures in orthognathic surgery, Rhine Valley Dental Society, Lahr, W. Germany.
10. 1979 - Maxillofacial trauma in the military environment, C.A.O.M.S., Quebec City.

PAPERS PRESENTED: (Continued)

11. 1981 - Exodontia from the seated position, NDMC Ottawa, Ontario and Rhine Valley Dental Society, Lahr, W. Germany.
12. 1982 - Condyle-eminence or bite plane, Graduate Oral Surgery Seminar, Victoria General Hospital, Halifax.
13. 1983 - Surgical removal of teeth - Head and neck infections of odontogenic origin - Antibiotic therapy, Newfoundland Dental Association, Corner Brook.
14. 1983 - Surgical management of cervicofacial infections, Review Course Oral and Maxillofacial Surgeons, Dalhousie University, Halifax.
15. 1984 - Overview of Oral Maxillofacial Surgery, V.G.H., I.W.K., and Infirmary O.R. Nurses Association
16. 1984 - Current Surgical Management of Osteoradio Necrosis - Graduate Oral Surgery Seminar, Halifax.
17. 1985 - Oral surgery for the general practitioner, Rhine Valley Dental Society, Baden, FRG.
18. 1985 - Current concepts of facial trauma management - Atlantic provinces dental convention, Halifax.

COURSES:

- 1984 - AO/ASIF Maxillofacial osteosynthesis - Jacksonville, FLA.

MEETINGS:

- 1980 - AAOMS Annual Meeting
1980 - CAOMS Annual Meeting
1981 - AAOMS Annual Meeting
1981 - CAOMS Annual Meeting
1982 - AAOMS Annual Meeting
1983 - AAOMS Annual Meeting
1984 - AAOMS Clinical Congress - Implants and TMJ surgery

MEETINGS: (Continued)

- 1984 - AAOMS Annual Meeting
- 1985 - Dallas Annual Clinical Symposium - Orthognathic surgery
- 1985 - Atlantic Provinces Dental Convention
- 1985 - CDA Annual Convention
- 1985 - AAOMS Annual Meeting
- 1986 - AAOMS/AAO Joint Clinical Congress

SOCIAL CLUBS:

1. Stadacona Squash Club, Member
2. Scotia Branch Legion, Member
3. German Wine Society, Member
4. New Glasgow Squash Club, Member
5. Abercrombie Golf and Country Club, Member

INFORMATION SERVICES

CURRICULUM VITAE

Name W.R. Howaniec
Address 202 - 5481 Kingsway
Burnaby, B.C. Postal Code V5H 2G1
Office Telephone No. 438-8238 Area Code 604

Personal Born - May 3, 1941
Married with two children: a boy 14 years
and a girl 12 years

Education Dental degree - University of Alberta

Memberships Seymour Golf Club
Burnaby Racquet Club
Associated Wildlife Preserves
Vancouver & District Dental Society
Served as a Director of Associated Wildlife
Preserves, and President of Gyro Service Club
Served on the Public Relations Committee for
the College of Dental Surgeons, and managed
the College Dental Clinics throughout B.C.

Interests Salmon fishing and racquetball

INFORMATION SERVICES

CURRICULUM VITAE

Name GASTON LAFRENIERE
Address 4 Taschereau
HULL (Quebec) Postal Code J8Y 2V5
Office Telephone No. 777-8583 Area Code 819

- Gradué Faculté en médecine dentaire - Université de Montréal en 1954
- Administrateur ODQ - 1976 à 1984
- Membre du Comité d'information - ODQ - 1980 à 1985
- Membre du Comité des services d'information de l'ADC depuis trois ans.
- Membre fondateur et président du Club Kiwanis de Hull - 1960
- Diplômé de Service méritoire - Croix Rouge
- Activités sportives: golf, tennis, ski
- Membre de la Société dentaire de Hull depuis le début.

COUNCIL ON STUDENT AFFAIRS

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Council Members: Miss Liliane LeSaux, Chairman, U. of Western Ontario
Mr. Bob Barr, U. of Manitoba
Dr. Dan Beck, Past Chairman, Vancouver, B.C.
Mr. Gale Blischak, U. of Saskatchewan
Mr. Martin Bourgeois, Dalhousie U.
Mr. Norman Clement, McGill U.
Miss Joanne Collins, U. of Toronto
Mr. David Ciriani, U. of British Columbia
Mr. Tony DeLauri, U. Laval
Miss Mireille Homsy, U. de Montréal
Dr. Greg Lovely, Past Student Governor, Lockeport, N.S.
Mr. Robert McCashew, U. of Alberta
Dr. Sam Sgro, Student Governor, Montreal, Quebec
Miss Pam Zakarow, U. of Western Ontario

Dr. John Christie, Executive Liaison

1. Council Meetings

Council has met once since the Interim Board meeting, on April 7, 1986, at CDA Headquarters.

Items Not Requiring Board Action

2. Practice Management Manual

Further to the Board's approval of the continued revision of the Practice Management Manual, Council feels that promotion of the Manual at the dental faculties warrants investigation.

Information was forwarded to Council by Dr. P. Ralph Crawford on the American Dental Association's program entitled Options '85, a one-day practice management seminar held at the dental schools, which supplements the distribution of the ADA manual on practice management. These seminars have been corporately sponsored through the American Fund for Dental Health, and have received positive response from the sponsors, faculty and students.

Particular areas of concern which Council will address in its investigation, will be the possible creation of conflict in the schools with their PM programs, and if, in fact, additional interest in the Manual would be generated as a result of such a program. If it is initiated, it would be with the approval and cooperation of the schools.

The cost and feasibility of developing such a program will be further investigated.

3. Canadian Fund for Dental Education

One of Council's ongoing objectives is the promotion of the CFDE to the student body, in the hope of creating a higher profile and awareness of the Fund. The means by which this can be accomplished is found to be a difficult one. Some schools hold special events and sports activities, with the proceeds directed to the Fund. Members have attempted to inform their peers of the CFDE's contributions to dental research and education, and are endeavouring to gain the cooperation of the Deans and faculty, in informing students on how the yearly CFDE grants to the schools are utilized.

Council also felt that feedback to the CFDE on the Students' Conference, which is sponsored by the Fund, should occur, and this was done via correspondence from each Council member to the CFDE, stressing the value of CDSC, and at the same time informing the Fund of how they are promoting it at their respective schools, and generally to relay its support.

4. Prelicensure

The Council on Student Affairs was represented at the Prelicensure Conference in February by Liliane LeSaux, who reported back on the proceedings.

Council's discussions on this issue encompassed the necessity of a review of the dental curriculae and predental education, as a possible solution. It was felt that predental education could be expanded to include material now being taught in the dental program.

Council feels that it is the responsibility of the dental schools to ensure that graduates are ready to practice at the termination of dental studies. Most students feel that the program is a long enough period of time and most are anxious to proceed with their dental careers.

Council is appreciative of the opportunity to be involved in this important issue and hopes to be able to continue to participate.

5. Student Membership

Student membership figures for 1985-86 remained at a high level, with 96% of all undergraduate students enrolled.

The student membership fee will increase by \$1.00 to \$14.00 in 1986-87, in keeping with the general membership fee increase.

6. Canadian Dental Students' Conference

Planning of the 1986 Students' Conference to be held in Halifax, September 24-27, is proceeding well. Dalhousie University will host a luncheon, a tour of the Faculty of Dentistry, and will schedule a lecture for delegates.

It is anticipated that the annual Student Information Night, hosted by the Nova Scotia Dental Association, will be held during the timeframe of the Conference, providing delegates with the opportunity to meet with Dalhousie students.

For ease of site selection, previous Student Conferences have been planned in the city where the CDA National Convention was being held that particular year, also normally the locale of a dental school. For 1987, however, because Saskatchewan is not on the schedule of a future Convention site, it was decided that CDSC'87 be held in Saskatoon.

7. CSA Representation at Other Meetings

Council is appreciative of the opportunity to be represented at the following meetings:

National Dental Examining Board of Canada
American Student Dental Association
ACFD Biennial Conference
Council on Education and Accreditation
CDA Board of Governors

This provides Council with a broader understanding of all aspects of organized dentistry.

8. 1986 CDA Grad Packs

The grad packs were again distributed to all CDA members. These were forwarded to the schools in May, and in some instances, were distributed at the graduates' luncheons or dinners.

Composition of the package included a congratulatory letter from Dr. B.W. Holmes; the May 1986 CDA Journal; March 1986 CDA Communiqué - DAP issue; DAP report, poster, button, decal, Chatelaine supplement; a copy of each CDA pamphlet and order form; CDA information brochure on Councils and Committees; the CDA Code of Ethics; a memo from Dr. R. Hicks on the tax deduction on instruments and libraries purchased during education and subsequently brought into use in a practice; Resource Centre information and a change of address form.

Summary

On behalf of the Council on Student Affairs, I would like to express the appreciation of all Canadian dental students to the Canadian Dental Association for their support and interest, and in particular for the generous contribution to the dental faculties in support of student representation at the ACFD Biennial Conference, and the opportunity extended to Council for a voice in the deliberations on the prelicensure issue.

Respectfully submitted,

Liliane LeSaux
Chairman
Council on Student Affairs

ADOPTION OF REPORT

The Board of Governors accepts the report of the Council on Student Affairs with appreciation.

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

I. Fourteenth Biennial Conference on Education and Research - June 1986

The Biennial Conference was very ably, hosted by the Faculty of Dentistry of the University of Toronto at the Nottawasaga Inn, in Alliston, Ontario. The topics were both timely and provocative which resulted in a large attendance and a successful meeting. The Research component dealt with "Applied Clinical Research", and a special related symposium, supported by the dental faculties and the CADR, was held in conjunction with the Biennial Conference. "Dental Students - Some Like It Not" was the theme for the Education component. It brought forward an important perspective on dental education and provided a basis for further discussion and action at the dental school level. We are grateful for the support provided for the conference by various funding agencies but in particular for the support provided by the CDA for the attendance of the dental student representatives. It provided an opportunity for interaction and a chance to be aware of the important relationship that exists between the CDA and the dental faculties.

II. Affiliate Members

The Association welcomed five new affiliate member institutions - two from British Columbia and three from Ontario. These new affiliate members represent colleges that provide education programs in dental assisting and dental hygiene. The Dental Hygiene Educators section of the Association has been renamed the Dental Auxiliary Educators section, and we believe that the Association will be able to provide a forum and support for these educators to discuss, at the national level, their mutual interests and concerns.

III. Summer Teaching Institute

The highly successful Institute which was held last Summer at the University of British Columbia was held this year at the University of Western Ontario. Support for this important faculty activity has come through the generosity of the Canadian Fund for Dental Education in conjunction with the faculties of dentistry. We look forward to an expanded program next year, which will involve more of the "middle management" faculty members in a program that will assist them in becoming more proficient in the administration of the academic program at each Faculty.

ASSOCIATION OF CANADIAN FACULTIES OF DENTISTRY

IV. Self-Assessment Program

The ACFD/AFDC continues to provide enthusiastic support for the conjoint effort in self-assessment of practitioner competency and is willing to assist in this endeavour in any way possible. In addition, the Association will be undertaking the development of a policy statement with regard to the faculties' role and responsibility in assisting with retraining/remedial opportunities for the profession.

V. Future Directions

As a result of the activities that have occurred nationally over the past year, i.e. the CDA Manpower Conference, and the CDA/NDEB Joint Conference on Mandatory Prelicensure, and their obvious relationship to curriculum reform, ACFD/AFDC supports the concept that these matters are all interrelated and will certainly affect the future direction of our profession. In order to address these issues and their implications, a joint master planning approach of the constituencies concerned must be undertaken. ACFD/AFDC plans to spearhead a working group representing all of the concerned parties to work swiftly toward that end. More details of this proposal will be presented at the time of the Board of Governors Meeting.

With respect to future location of the Association, we are investigating the potential for the organization to change its headquarters to Ottawa. It is my hope that this will come to fruition in the not too distant future.

Like the CDA, as an Association who is very much concerned with and has a responsibility to the dental profession, we look forward to having the opportunity to continue to work cooperatively together. As always, we are pleased to be able to present a report to the Board of Governors and would welcome your comments.

Respectfully submitted,

Marcia Boyd, D.D.S, M.A.
President

ADOPTION OF REPORT

The Report of the Association of Canadian Faculties of Dentistry received as information by the Board of Governors, with thanks.

NOTES ON ACFD/AFDC REPORT TO CDA EXECUTIVE

ESTABLISHED

MARCH 1967 (20 Years Young)

PHILOSOPHY/GOALS

"That it is most important that this organization work to establish national standards in research as well as educational policies..." April 1967.

- Objectives - promote the advancement of teaching and research in dentistry;
- facilitate the exchange of information and opinions among those engaged in dental education and research;
 - promote the provision of dental personnel to meet Canada's present and future health care requirements;
 - promote the development of postgraduate and graduate dental education;
 - promote opportunities for the continuing education of dental personnel;
 - promote public understanding and appreciation of the quality and value of education in research;
 - finally, engage in any activity consistent with the ethics of the profession and with the constitution and bylaws to advance the interest of dental education and research.

Note:- these very much parallel to and compliment the objectives of the CDA.

MEMBERSHIP:

- (a) Institutional - all ten faculties
- all full time faculty members.
- (b) Affiliates - any CDA accredited dentally related educational programme
- Canadian Forces
 - Community colleges (dental assisting and dental hygiene) Note:
- Note:- ACFD supports the accreditation process of the CDA.

FINANCES

- supported by membership dues, special grants for specific activities from CDA (e.g. Biennial support for students), CFDE, MRC, etc.

STRUCTURE

- (a) Executive - 8 members, including chairmen of standing committee on education and research
- Note: - also representative from the CDA Council on Education and Accreditation
- (b) Standing Committees
- education
 - research
 - constitution
- (c) Sections
- dental auxiliary education
 - clinic administrators
 - curriculum co-ordinators
 - ? future, continuing education

(d) House of Delegates

- institutional members (dean, plus 2 elected delegates)
- Canadian Forces
- representative of affiliates
- other invited bodies to report CDA (accreditation, education, students, etc.) NDEB, CFDE, MRC, Health and Welfare, etc.

MEETINGS:

Annual House of Delegates meeting and a Biennial Conference on Education and Research.

SPECIAL SYMPOSIA: example: Gerontology, Clinical Research, annual Teaching Conferences sponsored by CDA through ACFD and CFDE.

COMMUNICATIONS: - ACFD/AFDC Newsletter
- local committees

RELATIONSHIPS WITH OTHER BODIES:

- CDA
- NDEB
- CFDE

ISSUES AND INTERESTS: The same as CDA, example: manpower, education, continuing education, retraining, advancement of the profession through research, better dental health care and delivery to the public, etc.

FUTURE: - Continue to support one another and work together toward mutual goals
- to benefit of profession, public and the Associations.

MAB/mc

File Ref: RD/MB/CORRES;ACFD/CDANOTE

CANADIAN DENTAL HYGIENISTS ASSOCIATION

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Once again CDHA has prepared a summary of its years relevant activities for the CDA Board of Governors.

CDHA-CDA MANAGEMENT MEETINGS

Our on-going discussions with CDA at these management meetings have been successful. It is hoped that these meetings will be expanded in the future to insure that there continues to be constructive dialogue with the CDA and promotion of the interaction of the two organizations.

ORAL RESOURCE PACKAGE FOR THE ELDERLY

One of the highlights of our year was the sponsoring of our oral resource package for the elderly by Health and Welfare Canada. This package is a comprehensive educational resource for the elderly which will be distributed to senior citizens all across Canada in April of 1987. We hope to provide information and promote this "Smile For Life" package through the CDA Journal this fall.

PORTABILITY

CDHA continues to work towards provincial reciprocity for Canadian hygienists. A steering committee has been formed to do preliminary work for development of a national board exam for hygienists. Final development of the exam is contingent upon acceptance of the exam as a standard for licensure in all provinces. It is hoped this committee will be a joint CDA-CDHA effort.

NATIONAL SURVEY

In 1987, CDHA will be mounting a human resource survey of all hygienists in Canada. Coordinating the survey will be Pat Johnson, our representative to the CDA Professional Human Resources Committee, and Statistics Canada Data Bank.

CANADIAN DENTAL HYGIENISTS ASSOCIATION

CDA DENTAL AWARENESS CAMPAIGN

CDHA recognizes the Dental Awareness Campaign as a valuable educational tool. As education and prevention are the primary focus of the hygienist, CDHA would like to play an active role in the promotion of the Dental Awareness Campaign.

CDSPI

CDHA is very pleased to have registered retirement savings plans with CDSPI made available to hygienists. We are currently utilizing CDSPI to underwrite our malpractice insurance coverage, on an individual participation basis. We will be reviewing the policy at our annual board meeting.

Respectfully submitted,

Audrey Newcombe, President
Canadian Dental Hygienists
Association

ADOPTION OF REPORT

The Report of the Canadian Dental Hygienists' Association received as information by the Board of Governors, with thanks.

CANADIAN FUND FOR DENTAL EDUCATION

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

1. Since reporting to your Board's Interim Meeting earlier this year, CFDE held its annual meeting on April 27-28. It was the first annual meeting for me as Chairman of the Fund's Board of Trustees and it gives me much pleasure to provide you with detailed information on the decisions made and discussions held at that time.

Items for Information - Not Requiring Board Action

2. All Trustees were present for the meeting. I was particularly pleased to welcome the newly-appointed Trustees, Dr. Stuart Foster of Calgary, Dr. Ted Ramage of Vancouver, Dr. Gordon Thompson of Edmonton and Mr. Jardine Neilson, your Association's Executive Director. Also attending the meeting was Dr. Robert Brandon of London, Ontario, who has expressed a willingness to assist with some of the Fund's activities.
3. The 1985 minutes of the Board and Management Committee meetings were approved as distributed.

Auditors

4. The Trustees accepted and approved the auditors' report and financial statements for the year ended December 31, 1985. They appointed the firm of Thorne Riddell as auditors to serve until the next annual Board meeting.

Establishment of Ad Hoc Committee

5. Since the Fund's inception in 1962, the Trustees have always supported educational and research programs considered at the time to be the most effective in meeting the needs of the profession and the public. To ensure the Fund's granting priorities were in tune with the latest community requirements and professional attitudes, the Trustees, in 1980, established an Ad Hoc Committee under the Chairmanship of Dr. W.G. McIntosh to make recommendations for the Fund's granting priorities for the next five-year period and on ways and means of reaching these objectives. The recommendations of the report were summarized for the benefit of the Trustees at the 1986 annual meeting.

CANADIAN FUND FOR DENTAL EDUCATION

Establishment of Ad Hoc Committee (cont'd)

6. While CFDE has already advanced in new directions, the Trustees' discussion reflected the unanimous feeling that the Fund's granting priorities require further study and evaluation at this time in light of the major changes which dental education, research and practice have undergone in recent years.
7. The Trustees are always grateful for the support received from members of the profession. However, they do have a continuing deep concern over the fact that such a high percentage of dentists do not contribute to CFDE. They are also cognizant that donation income from business and industry has decreased over the past two years. Therefore, it is essential that the Fund's profile be heightened and marketed more effectively to ensure greater participation by the profession and dental industry.
8. The Board's discussion resulted in a resolution authorizing the Management Committee to form an Ad Hoc Committee to establish guidelines on marketing and funding and to review the perceived values of the Fund.
9. It is hoped that a preliminary report will be available for the next meeting of the Management Committee, with the final report to be submitted to the Trustees at their 1987 annual meeting.

Fundraising

10. A review of CFDE's fundraising activities and its promotional materials will form part of the assignment of the Ad Hoc Committee which is to be established. The Trustees look forward to the recommendations made by the Committee.
11. In the interim, the Trustees agreed to follow, in 1986, the Fund's established method of raising funds from the profession, business and industry.
12. In addition, and in an effort to generate a larger response from previous dentist contributors, it was agreed to forward, next November, a personalized reminder letter to those who have not so far donated in the current year.

CANADIAN FUND FOR DENTAL EDUCATION

Fundraising (cont'd)

13. The 1985 telemarketing campaign in Ontario did not prove a positive experience and will not be repeated this year. The Trustees directed, however, to develop a special solicitation letter to be sent to those dentists who responded with a donation to the telemarketing approach in an attempt to maintain their support.
14. It will be recalled that our Trustee, Dr. Sidney Golden, offered to organize a lottery in Ontario in the spring of 1986, the prize to be in the form of two airline tickets to and hotel accommodation at the site of the FDI World Congress. Manila, the site of the 1986 FDI Congress, did not seem sufficiently attractive to guarantee wide participation in the lottery and, therefore, Dr. Golden decided to postpone the project until 1987 when the FDI Congress will be held in Argentina.

Advisory Committee on Fellowship Selection

15. Dr. Wesley Dunn, Chairman of the Advisory Committee, joined the Trustees to personally present his report.
16. The 1986 meeting of the Advisory Committee was held on Monday, April 21, with all members in attendance. In addition to Dr. Dunn, Dr. Ralph Barolet and Dr. Gordon Nikiforuk serve on the Committee. At Dr. Dunn's invitation, Mrs. Linda Berry, on behalf of the Canadian Dental Hygienists' Association, attend that portion of the Committee meeting which focused on matters pertaining to dental hygienists.
17. This year there were two excellent applications for the Warner-Lambert sponsored award for an existing university dental teacher. The Committee selected Dr. D.W. Lewis, Professor of Community Dentistry at the University of Toronto, as the recipient. The award, with a value of \$2,500, will permit Dr. Lewis to further his study of clinical epidemiology.
18. The Committee continues in the view that the Warner-Lambert sponsored award fulfills an important purpose but regrets that more applications are not generated. The Committee is, however, convinced CFDE is doing everything reasonable to bring information concerning the fellowship to the attention of all Canadian dental schools. One clarifying amendment to the conditions of the award was recommended.

CANADIAN FUND FOR DENTAL EDUCATION

Advisory Committee on Fellowship Selection (cont'd)

19. Five dentists reapplied for CFDE fellowship support and 11 new applications (one from a non-dentist) were received. Awards for four of the five reapplicants were recommended by the Committee, the fifth was rejected because the earlier firm commitment to a faculty appointment was absent from this year's application. Of the 11 new applicants, two were adjudged to be ineligible, the remaining nine were recommended for support. One of the new applicants is a pharmacist employed by a Faculty of Dentistry. Upon completion of her Ph.D. program she will return to full-time status, which will include teaching and research.
20. Three dental hygienists applied for fellowships this year. Two were recommended for support, the third considered ineligible.
21. The Committee, after carefully reviewing all applications, considered the application of Dr. Allen R. Burgoyne to be the most meritorious. Accordingly, Dr. Burgoyne was selected as this year's recipient of the Henry M. Thornton Fellowship. The award carries a value of \$1,000.
22. Dr. Dunn also brought to the Trustees his Committee's concern relative to the current interpretation of an 'institutional commitment' and the request that the Committee members be permitted to satisfy themselves from the accompanying statements as to whether or not there is 'as firm as possible' an institutional commitment and overwhelmingly strong support for the eventual candidature of the applicant being considered.
23. The total value of the fellowships recommended was \$87,000. The Committee submitted to the Trustees suggestions to reduce the total to \$60,500, should the Fund's resources not permit full funding.
24. This, however, proved to be still \$20,000 more than the Trustees were able to allocate for fellowships this year and a resolution was passed to request the Advisory Committee to further reduce the fellowships to \$41,500 with consideration to be given to obtaining a reasonable distribution of the awards amongst institutions.
25. The revised recommendations, based on a further reduction in the value of the fellowships as well as a reduction in the number of fellowships awarded to new dentist applicants from nine to five, have been received from the Chairman of the Advisory Committee and were approved, by mail ballot, by the Fund's Management Committee.

CANADIAN FUND FOR DENTAL EDUCATION

Advisory Committee on Fellowship Selection (cont'd)

26. The task of the Advisory Committee on Fellowship Selection is an important and difficult one. The Trustees are deeply indebted to the Committee members for their invaluable assistance and unanimously passed a resolution to express their deep appreciation.

Grants Approved for 1986

27. The Trustees were pleased to approve a total of \$175,000 in grants to benefit the profession in 1986. In addition to the above fellowships, the following are the major programs selected for support this year:
28. The XIV Biennial Conference on Dental Education and Research will be held in Alliston, Ontario, June 7-13. CFDE has provided major funding for this important Conference for many years. In my report to your interim meeting this year, I advised that the Fund's Management Committee approved a grant of \$10,000 in support of the meeting, and it gives me much pleasure to let you know that the Trustees, at their annual meeting, were able to increase this grant to \$12,500.
29. The sum of \$20,000 will go towards the second Summer Teaching Institute organized by the Association of Canadian Faculties of Dentistry.
30. A total of \$20,000 was allocated for programs to increase public demand for dental health care. The Trustees gave approval in principle to an expenditure of up to \$10,000 for a project within CDA's Dental Awareness Program to be identified and presented by CDA for approval by the Fund's Management Committee. The remaining \$10,000 will support the ODA Computerized Dental Check-Up Program (\$5,000), National Dental Health Month (\$4,000), and a summer student program.
31. Upon application, an unrestricted grant of \$1,500 will be awarded to each of the ten Canadian dental schools. These grants are most helpful to the deans in these difficult financial times.
32. The Trustees were also pleased to continue their funding of \$1,000 per dental school for the direct benefit of dental students. Since 1983 these grants have been used in various ways, as decided by each dean. At this year's annual meeting, the Trustees agreed that, commencing with the 1986-87 academic year, the grants should be used exclusively for the provision of scholarships and directed that the deans be so advised.

CANADIAN FUND FOR DENTAL EDUCATION

Grants approved for 1986 (cont'd)

33. Both the Student Clinician Program and the Students' Conference will be supported again this year. Grants of \$8,000 and \$7,500 respectively have been set aside for these events.
34. The 1986 Teaching Conference on Periodontics will also receive CFDE funding of \$7,500.
35. The Trustees will provide a total of \$9,500 for the following dental hygiene programs: The CDHA Continuing Education Conference 'Let's ALL Learn', scheduled for August 27-28 in Halifax, will be supported with a grant of \$6,000 from CFDE's general funds. In addition, CFDE will be pleased to accept earmarked gifts for the Conference. The CDHA Dental Educators' Workshop, which CFDE has supported on three previous occasions, will receive assistance of \$1,500. The remaining \$2,000 grant, underwritten by a corporate sponsor, will go towards ODHA educational projects.
36. The Trustees were able to provide a \$3,000 grant to assist with the translation into French of a Preventive Dentistry Manual. The project is carried out by Dr. D. Kandelman at the University of Montreal.
37. The income from the Lorne E. MacLachlan Endowment Fund of approximately \$10,000 will again this year be divided equally between the dental faculties at Toronto, Western Ontario, McGill and Dalhousie to benefit the Prosthodontics Departments in accordance with the terms governing the Endowment.
38. Finally, I wish to advise that a grant of up to \$2,500 (Can.) has been approved in support of the Health Screening Examination for Dentists attending the CDA Convention in Halifax. The Trustees requested that more detailed budget information be made available to CFDE to allow the Fund's Management Committee to decide on the final amount of the grant.

CFDE/ACFD Summer Teaching Institute

39. It will be recalled that, commencing in 1984, and for a duration of three years, CFDE approved a grant of \$20,000 per annum, which enabled the Association of Canadian Faculties of Dentistry to conduct two Summer Teaching Institutes with follow-up programs, designed to improve the teaching skills of dental faculty members.

CANADIAN FUND FOR DENTAL EDUCATION

CFDE/ACFD Summer Teaching Institute (cont'd)

40. Dr. John Eisner, Chairman of ACFD's Education Committee, attended part of the Fund's annual meeting to report to the Trustees on the success of the Institute so far and to submit a funding request for the continuation of the program.
41. The proposal for the continuation of the Institute combines the elements of the two previous Institutes with a new course aimed at the very critical middle management level entitled 'Managing the Academic Program'.
42. The Trustees unanimously agreed with the positive aspects of the Summer Teaching Institute and its success to date. They approved funding of \$35,000 for a 1987-88 Institute and requested that the program henceforth be officially called "The CFDE/ACFD Summer Teaching Institute".

National Self-Assessment/Education Program for Dentists

43. Dr. Kenneth Bentley, Chairman of CDA's Continuing Education Committee, personally addressed the Trustees on his Committee's assignment to develop a Pilot Project relative to a national Self-Assessment/Education Program for Dentists.
44. I am pleased to report that the Trustees approved a grant of \$6,000, for payment in 1987, to assist with the funding required for the Pilot Project.

Murray McDonald Memorial Lecture

45. In his report to you last year, my predecessor, Dr. David Peters, was pleased to announce that the CFDE Trustees had unanimously decided to perpetuate the memory of Mr. Murray McDonald, CFDE's Executive Director for fifteen years, by establishing the "Murray McDonald Memorial Lecture". A Committee, under the Chairmanship of Dr. Peters, was set up to draft guidelines and a potential roster of lecturers for consideration by the Trustees at their 1986 annual meeting.
46. The Committee's report was received by the Trustees. In light of the organizational work involved and the limited success of some of the presentations by Dr. William May, an outstanding ethicist and the first speaker of the Memorial Lecture, opinion is divided as to the format for the continuation of the Memorial Lecture and two options were offered for the Trustees' consideration.

CANADIAN FUND FOR DENTAL EDUCATION

Murray McDonald Memorial Lecture (cont'd)

47. The Trustees felt several points needed clarification. They also expressed a deep concern regarding the long-range outlook for the Lecture in its present or proposed format.
48. As a result, they passed a resolution referring the report back to the Committee for clarification and for re-evaluation of the Lecture as an appropriate vehicle to commemorate Mr. McDonald.

Relocation of CFDE Office

49. Just prior to the Fund's annual meeting, CFDE was informed that its current lease will not be renewed at the expiry date of August 31, 1986. The Trustees authorized the Management Committee to secure a new office location for CFDE.

Board of Trustees

50. Mr. Douglas Rutherford has served on CFDE's Board for six years and his final term of office expires in 1986. The Trustees recorded a unanimous vote of thanks for his outstanding service to the Fund during his tenure as a Trustee and Vice-Chairman.
51. I will be pleased to nominate a successor to Mr. Rutherford at the CDA Board meeting.

RESOLVED:

- 86.108 THAT the appointment of Dr. Robert Cajolet
 to the Board of Trustees be approved.**

ADOPTED

52. Dr. William Campbell, whose first term of office expires this year, kindly agreed to serve for a second term of three years.
53. Mr. Fred Heaps was reappointed Vice-Chairman of the Fund to serve until the 1987 annual meeting of the Trustees.

Management Committee

54. Lately the Fund's Management Committee has consisted of three members, two representing the dental profession and one representing business and industry. The Trustees felt it would be more beneficial to have a third representative from the profession on the Committee.

CANADIAN FUND FOR DENTAL EDUCATION

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55. The following were appointed to serve on the Management Committee until the 1987 annual meeting of the Fund: J.F. Reid (Chairman), F.J. Heaps (Vice-Chairman), L. Bernier and S. Golden.

Appreciation

56. As we all know, CDA's cooperation and support are essential to the Fund's ongoing progress. My fellow Trustees and I extend our deep appreciation to all in the Association who have so generously assisted our efforts. We are confident we can count on your continued help in 1986 and beyond.
57. I wish to close with a special word of thanks for CDA's substantial contribution to CFDE which I was delighted to receive recently. I can assure you it will be of significant help in meeting our objectives this year.

Respectfully submitted,

J. Fred Reid, D.D.S.
Chairman
CFDE Board of Trustees

ADOPTION OF REPORT

The Report of the Canadian Fund for Dental Education received as information by the Board of Governors, with thanks.

ROYAL COLLEGE OF DENTISTS OF CANADA

REPORT TO THE 1986 ANNUAL BOARD OF GOVERNORS, CDA

The College will be holding both Membership and Fellowship Examinations in June this year and again in December, so that both examinations will be held twice. Approved candidates at the time of writing number as follows:

	<u>Membership Exam.</u>	<u>Fellowship Exam.</u>
Endodontics	-	1
Oral and Max. Surgery	6	3
Oral Pathology	1	-
Oral Radiology	1	1
Orthodontics	2	-
Paedodontics	3	-
Periodontics	6	-
	—	—
	18	5
	—	—

Written examinations will be held in Vancouver, Edmonton, Winnipeg, Toronto, Halifax and Iowa City. Successful examinees will be admitted to the College at its Convocation to be held in Halifax on Friday, August 22nd, together with eleven (11) new Fellows from the December, 1985, examinations.

Despite the success of the College's Symposium on Facial Pain given as part of the CDA's Scientific Program in September, 1985, the College absorbed a financial loss. Since there is no separate registration fee for the Symposium, this loss was not an outcome of the general low attendance at the Convention, but was due to the fact that previous donors did not give support last year.

Normally, the next Symposium would have been held in 1987, and this has been cancelled since, at the time of writing, we do not yet know the place or dates for your 1987 Convention. We will begin working with your Scientific Chairman for 1988 towards holding our next Symposium in Edmonton.

The Council of the College is composed of one representative from each recognized specialty and the Dental Sciences group; the exceptions are Oral and Maxillofacial Surgery and Orthodontics, which each have two representatives. Up until 1985 these were the only two specialties having more than 50 Fellows in the College, and were permitted within the By-laws to have two representatives. Several other specialties are now eligible to elect more than one representative, and the Executive Committee will recommend to Council in August that all specialties, regardless of their numbers in the College, have only one representative on Council. We are in the process of consulting with the specialty associations on this issue.

Requirements for the Fellowship Examination have undergone a recent review and modification in some specialties, so that the clinical requirements may better reflect the changing aspects of practice. These modifications are already in effect, and an updated edition of the booklet "Information for Applicants" should be available by late Summer.

Respectfully submitted,

Michal J. Crompton
President

ADOPTION OF REPORT

The Report of the Royal College of Dentists of Canada received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF ENDODONTICS

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

1. Items for Information - Not Requiring Board Action

The annual meeting of the Canadian Academy of Endodontics was held in conjunction with the Canadian Dental Association in September, 1985 in Ottawa. Members and guests enjoyed an excellent scientific meeting which featured Dr. Franklin Weine of Chicago as the keynote speaker. Dr. Lorne Chapnick was scientific chairman for the meeting and Doctors B. Dolansky and G. Citrome looked after local arrangements.

Our next annual meeting will be held September 25-28, 1986 in Vancouver, B.C.

Dr. J. Phillips and Dr. F. Weinstein attended the C.D.A. sponsored meeting of speciality groups in Ottawa in April and enjoyed a very constructive and interesting meeting.

The annual general meeting elected the following executive for 1985-86:

Past-President	Dr. Barry Korzen, Willowdale, Ontario
President	Dr. Fred Weinstein, Vancouver, B.C.
President-Elect	Dr. Herb Borsuk, Montreal, Quebec
Treasurer	Dr. Wm. Christie, Winnipeg, Manitoba
Executive Secretary	Dr. John Phillips, Oshawa, Ontario

Respectfully submitted,

John M. Phillips
Executive Secretary
Canadian Academy of Endodontics

ADOPTION OF REPORT

The Report of the Canadian Academy of Endodontics received as information by the Board of Governors, with thanks.

CANADIAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

REPORT TO THE 1986 ANNUAL BOARD OF GOVERNORS MEETING

Executive:	President	Precious, D.S.
	Past-President	Warren, R.
	Secretary	Lyons, B.
	Treasurer	Zosky, J.

ITEMS FOR INFORMATION - NOT REQUIRING BOARD ACTION

1. The 1986 annual meeting of the Association was held in conjunction with the IXth International Congress on Oral and Maxillofacial Surgery, Vancouver, B.C. - May 21-25.
2. The 1987 annual meeting of the Association will take place in Halifax, October 15-18, 1987. Clinicians include Doctors Wolford, Precious, Jensen and Soder. Chairman for this meeting is Dr. P. Cyr.
3. The Association is pursuing the possibility of a joint meeting with the Canadian Association of Orthodontists.
4. The members of the C.A.O.M.S. send their best wishes to the Board of Governors of the CDA.

Respectfully submitted,

Bernard Lyons, Secretary
C.A.O.M.S.

ADOPTION OF REPORT:

The Report of the Canadian Association of Oral and Maxillofacial Surgeons received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF ORAL RADIOLOGY

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

Officers: Dr. C.G. Baker, President
 Dr. D. Forest, President-Elect
 Dr. C. Price, Secretary-Treasurer
 Dr. C.G. Baker, Education Committee Chairman
 Dr. J.W. Halip, Membership Committee Chairman
 Dr. F.W. Musaph, Constitution and Bylaws Chairman
 Dr. H.G. Poyton, Historical Documentation Chairman
 Dr. D.W. Stoneman, Public and Professional Relation
 Chairman

1. Items for Information - Not Requiring Board Action

The fourteenth Annual Meeting of the Academy was held on June 2, 1985, at London, Ontario, under the chairmanship of Dr. John Reid.

The following papers were presented:

"Radiologic Analysis of Porous Surface Implants" - Dr. Bernard Friedland
 "Mucoepidermoid Carcinoma" - Dr. Garnet Pockota
 "Vanishing Bone Disease" - Dr. Bob Wood
 "Dental Implications of Nuclear Medicine" - Dr. Dale Miles
 "Oral Radiological Services" - Dr. Charles Baker
 "Magnetic Resonance Imaging of the Temporomandibular Joint" -
 Dr. Colin Price
 "Osteoblastoma of the Mandibular Condyle" - Dr. Mike Pharoah

Current membership consists of two Honorary, 18 Active, and 13 Associate Members.

During the year, there has been further communication between the Academy and the Health Protection Branch of Health and Welfare, Canada, about the Radiation Emitting Devices Act. Many of the earlier suggestions made by the Academy have now been incorporated into the Act. In the past, communications have been somewhat tenuous and relied on transmission of information by the CDA. We now have an agreement that the X-Ray Section of the Health Protection Branch will send to the Academy copies of all correspondence to CDA. This should streamline our communications.

CANADIAN ACADEMY OF ORAL RADIOLOGY

Following previous input, the Academy has been requested by the CDA to provide a revision of the Guidelines for the Control of Radiation in the Dental Office to the Council on Health Care. Our President, Dr. Baker, together with Dr. Reid, had been involved in updating the Health and Welfare document Oral Radiological Services and so undertook work on revising the Guidelines. A draft revision of the Health and Welfare document and also Guidelines prepared by the American Academy of Dental Radiology have been circulated to CAOR members for their suggestions.

Matters arising from the Specialty Sections Meeting of CDA have been discussed. These include referral forms, accommodation for specialty academies and associations, the Canada Health Act, and accreditation.

Proposed Guidelines for Advanced Educational Program in Oral Radiology have been developed by Dr. Stoneman and circulated to members.

The National Symposium on Dental Manpower in Canada was discussed in relation to Oral Radiology. In contrast to many fields of Dentistry, there is a perceived shortfall of trained oral radiologists.

Resource persons were provided from the Academy for the CDA Dental Awareness Program.

The fifteenth Annual Meeting of the Academy will be held as a conjoint meeting with the Eastcoast Dental Radiology Workshop. It precedes the CDA Convention at Halifax, August 22-24, 1986. Dr. D.A. Miles is to chair this meeting.

Respectfully submitted,

Colin Price
Secretary-Treasurer
Canadian Academy of Oral
Radiology

ADOPTION OF REPORT

The Report of the Canadian Academy of Oral Radiology received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

REPORT TO THE 1986 ANNUAL CDA BOARD OF GOVERNORS

1. Items Requiring Board Action

At the October, 1985 Annual Meeting of the Academy a motion was presented to change the name of the Specialty from Paedodontics to Pediatric Dentistry.

It is therefore recommended:

RESOLVED:

- 86.109 **THAT the documents and policies approved by the Canadian Dental Association which refer to Paedodontics be amended to reflect the change in designation to Pediatric Dentistry.**

ADOPTED

This matter was referred to the Council on Constitution and By-Laws for appropriate amendments.

For further details, see Appendix A.

APPENDIX A

Respectfully submitted,

Dr. Peter M. Pronych
Secretary-Treasurer
Canadian Academy of Pediatric
Dentistry

ADOPTION OF REPORT

The Report of the Canadian Academy of Pediatric Dentistry received as information by the Board of Governors, with thanks.

CANADIAN ACADEMY OF PEDIATRIC DENTISTRY

ACADÉMIE CANADIENNE DE DENTISTERIE PÉDIATRIQUE

May 23, 1986

Mr. A. Jardine Neilson
Executive Director
Canadian Dental Association
1815 Alta Vista Drive
Ottawa, Ontario
K1G 3Y6

Dear Mr. Neilson:

Please be advised that at the October, 1985 Annual Meeting of the Academy a motion was presented to change the name of the Specialty from Paedodontics to Pediatric Dentistry.

A resolution in form of a motion was passed by the Academy. The motion read:

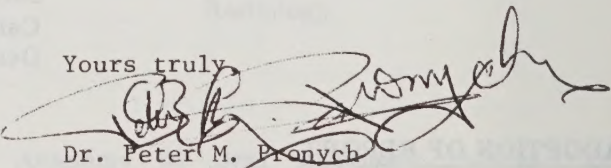
- "Be it 1) resolved, that the specialty currently designated Paedodontics be redesignated Pediatric Dentistry and be it further
- 2) resolved, that dental educational institutions consider redesignating departments of Paedodontics as departments of Pediatric Dentistry, and be it further
- 3) resolved, that provincial boards of dentistry consider changing their identification of the specialty of Paedodontics to Pediatric Dentistry, and be it further
- 4) resolved, that the documents and policies approved by the Canadian Dental Association which refer to Paedodontics be amended to reflect the change in designation to Pediatric Dentistry."

Please place item number four of the motion before the Board of Governors for their consideration at the June 27 - 28 meeting.

There are no further items or a report to be presented to the Board of Governors at this time.

Thank you.

Yours truly,


Dr. Peter M. Pronych
Secretary-Treasurer
Canadian Academy of Pediatric Dentistry

/bjm

cc: Dr. Frank Pulver, President

7 DAYS

THIS BOOK MAY BE KEPT FOR
7 DAYS ONLY
IT CANNOT BE RENEWED

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FACULTY OF DENTISTRY

124 EDWARD ST.

TORONTO, ONT.

TRANSACTIONS
of the Canadian Dental Association

DÉLIBÉRATIONS
de l'Association dentaire canadienne